



Turning **Bureaucrats**  
Into **Warriors**



Preparing & Implementing  
Multi-Sector HIV-AIDS Programs in Africa



*A Generic Operations Manual*



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# PREFACE





# Preface

At the end of 2003, UNAIDS estimated that an estimated 26.6 million people in Sub-Saharan Africa were living with HIV, there were some 10 million AIDS orphans, and the accumulated deaths from the epidemic had reached 20.4 million. Faced with this challenge, the international community and national governments have increased dramatically the funding of HIV-AIDS prevention, care and treatment, and mitigation programs. While there is still a need to increase the amount of funding, the most immediate challenge is to demonstrate that existing funding can be used efficiently, effectively and transparently. Regardless of the source of funding and of its “intended flexibility”, money flows through bureaucratic channels in the public sector and civil society according to fiduciary policies, procedures and practices whose implementation and interpretation by bureaucrats will either “empower” or “burden” implementing agencies. Recent experience has shown that bureaucrats in countries and in donor organizations have choices: they can either interpret policies and practices to maximize their flexibility or they can “play it safe” and interpret them narrowly. The purpose of this Generic Operations Manual (GOM) for Multi-Country HIV-AIDS Programs in Africa (MAP) is to provide guidance and lessons learned to turn HIV-AIDS bureaucrats, wherever they may be, into “HIV-AIDS warriors,” to recognize that halting the spread of the epidemic and reducing its impact requires a war-like commitment and a warrior mentality. Business as usual allows the epidemic to continue to devastate Africa, and the world. A declaration of war and turning bureaucrats into warriors are the best means of empowering the front line soldiers in implementing agencies in the public sector and civil society and those living in communities with the arms and ammunition to win the war.

These guidelines on preparing and implementing multi-sector HIV-AIDS programs are based on many lessons learned in Africa over the last three years and are designed as a generic operations manual (GOM) from which countries and implementing agencies can learn and adapt for their own use. The GOM is also meant to support the principles for concerted action at country level, the recently promoted “Three Ones” which are aimed at achieving the most effective and efficient use of available resources and ensuring rapid action and results-based management:

- **One agreed HIV-AIDS Action Framework that provides the basis for coordinating the work of all partners;**
- **One National AIDS Coordinating Authority, with a broad based multi-sectoral mandate;**
- **One agreed country level Monitoring and Evaluation System.**

**The GOM is an evolving document,** learning from experience and adapting continuously. The GOM was originally drafted in 2002 and reviewed in a variety of workshops for a over the two years, including (i) three workshops in Nairobi and Dakar for public sector and civil society MAP implementing and coordinating agencies from 25 African countries; (ii) two workshops in Addis Ababa and Accra for African faith-based organizations; and a workshop in South Africa for twenty MAP financial management and procurement country teams composed of MAP and World Bank fiduciary staff. In addition, versions of the GOM were shared with MAP implementing agencies and the lessons learned include the experience of preparing and implementing MAP programs throughout Sub-Saharan Africa over the last three years. While the principal authors are Jonathan Brown, Didem Ayvalikli and Nadeem Mohammad, a large number of people both inside and outside the Bank have made major contributions to the overall effort and to specific chapter, including: Elizabeth Ashborne, John Cameron, Frode Davanger, Cassandra de Souza, Sheila Dutta, Keith Hansen, Amadou Konare, Ayse Kudat, Kate Kuper, Jane Miller, John Nyaga, Sangeeta Raja, Dan Ritchie, Nina Schuler, Richard Seifman, Yolanda Tayler and David Wilson. The GOM was produced under the guidance of Keith Hansen, manager, ACTAfrica and Debrework Zewdie, Director, Global HIV-AIDS Program.

The GOM is presently organized around a number of chapters, some of which, especially on implementation agencies, are meant to be self-contained, and thus there is considerable repetition, especially with regard to fiduciary aspects, so that they can be used as stand-alone pieces for discussion with stakeholder groups. Most of the chapters in the GOM are complemented with relevant Annexes with specific country examples. List of all annexes are in the table of contents under their relevant chapter and can be located in the CD-ROM that is attached at the back cover of this publication along with other supporting information

**The GOM is meant as a “living document”**, to be updated continually on the basis of experience on the ground and to be used by anyone involved in HIV/AIDS programs who finds them useful. GOM is also available at <http://www.worldbank.org/afr/aids/> under the MAP manuals link. More detailed sub-manuals have also been produced on monitoring and evaluation, financial management, disbursement and reporting, general procurement, procurement of ARVs and medical devices, early childhood development, local government and the private sector.

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- Fiduciary Management for Community-Driven Development Projects A Reference Guide (English)
- Guidelines for the Preparation of a Project Specific Financial Management Manual for MAP Projects (English/French)
- Guidelines for Private Sector—National AIDS Commission Guidelines for Responding to HIV/AIDS (English/French)
- Operational Guidelines for Supporting Early Child Development (ECD) in Multi-sectoral HIV/AIDS Programs in Africa (English/French)
- Monitoring and Evaluation Manual (English/French)
- Battling HIV/AIDS: A decision Maker's Guide to the Procurement of Medicines and Related Supplies (English)
- Local Government Responses to HIV/AIDS Handbook (English/French/Portuguese)
- Condom Procurement Guidelines (English/French)
- Education and HIV/AIDS : A Window of Hope (English)

## Country Specific Manuals

<b>Burkina Faso</b>	Operational Manual
<b>Cape Verde</b>	Financial and Accounting Manual Operational Manual Waste Management Plan
<b>Gambia</b>	Operational Manual Community and Civil Society Initiatives (CCSI) manual/documents
<b>Malawi</b>	NAC Grants Operational Manual NAC Proposal Guidelines NAC Grant Agreement NAC Grants Facility
<b>Uganda</b>	Project Operational Manual

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# ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-RetroViral
ART	Anti-Retroviral Therapy
CBO	Community Based Organization
CDD	Community Driven Development
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DFID	Department for International Development - UK
EU	European Union
FBO	Faith Based Organization
FMA	Financial Management Agent
FMR	Financial Monitoring Report
FMS	Financial Management Systems
GFATM	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
GOM	Generic Operations Manual
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
ICB	International Competitive Bidding
IDA	International Development Association
IEC	Information, Education, and Communication
M&E	Monitoring and Evaluation
MAP	Multi-Country HIV/AIDS Program for Africa
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTCT	Mother-to-Child Transmission
NAC	National AIDS Commission
NAS	National AIDS Secreteriat
NCB	National Competitive Bidding
NGO	Non-Governmental Organization
OI	Opportunistic Infection
PLWHA	People Living With HIV/AIDS
PMTCT/PMTCT+	Prevention of Mother To Child Transmission and Family Support
PMU	Project Management Unit
STD/STI	Sexually Transmitted Disease/Sexually Transmitted Infection
TB	Tuberculosis
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNECA	United Nations Economic Commission for Africa
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's' Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WHO	World Health Organization

# PART I



Background and Justification





# Chapter 1

## Background

### 1. The purpose of the guidelines

Turning Bureaucrats into Warriors - Preparing and Implementing Multi-sector HIV/AIDS Programs in Africa is a Generic Operations Manual (GOM) that has been prepared to provide practical, timely, operational, and relevant advice, lessons learned, and examples for those involved in waging the war against the HIV/AIDS epidemic in Africa. This GOM has three main audiences: (i) National AIDS Councils and their implementing partners in the public sector and civil society, across the sectors and from the village to the national level; (ii) external institutions involved in assisting the preparation and implementation of HIV/AIDS programs, including specialized agencies and donors such as the World Bank; and (iii) institutions and people around the world who are more generally involved in the practical aspects of enhancing the effectiveness and efficiency of HIV/AIDS program implementation.

The GOM may be especially relevant for the preparation and implementation of multi-sectoral national HIV/AIDS programs which will be supported by donors, including the World Bank. It reflects the substantial flexibility available to implementing entities undertaking HIV/AIDS prevention, care and treatment and mitigation activities once a “fiduciary architecture” of financial management, procurement and disbursement mechanisms, and monitoring and evaluation are put in place. Therefore, the emphasis is on the “how” not the “what”, on the fiduciary architecture and the implementation channels for reaching beneficiaries, not on program activities themselves which are the subject of other guidelines and best practice examples by specialized institutions. While the GOM includes chapters on program activities, the emphasis of these chapters will be on preparation and implementation experience as this becomes available over the next few years, rather than on what programs in prevention, care and treatment and mitigation work best when, where and for whom.

The GOM includes lessons learned and examples of good practices and is meant as a living document to which additional lessons and good practices can be added by practitioners in real-time through: (i) an interactive website; (ii) meetings of practitioners; and (iii) annual country reviews. It may be especially appropriate for countries preparing HIV/AIDS programs or expanding existing programs since cross-country experience can help implementing agencies in the public sector and civil society which participate extensively and intensively in preparing operational manuals. The GOM represents a generic set of lessons learned that can be adapted for specific country and beneficiary conditions. Thus it is applicable for both high and low prevalence countries, for those with small and large populations, for those in a conflict or post-conflict situation as well as those with stable political environments. These lessons contained in the GOM will evolve with operational experience and time.

### 2. What is the Multi-Country AIDS Program (MAP)?

HIV/AIDS is the leading cause of death in Sub-Saharan Africa. By the end of 2003, more than 20 million Africans had died, there were than 10 million AIDS orphans, and another 27 million Africans were living with the virus, the vast majority of them in the prime of their lives as workers and parents. Life expectancy continues to drop, family incomes are being decimated, and agricultural and industrial efficiency is declining because of the epidemic. In 16 countries, more than one of every ten adults is HIV-positive. More than 10,000 Africans are newly infected each day, nearly four million every year. If effective action is not taken, the Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that 40% of today’s 15-year olds will ultimately acquire HIV/AIDS in countries such as Ethiopia and Cote d’Ivoire and 60% in countries such as South Africa and Zambia.



African nations and the international community have recognized the disaster the epidemic is raining on the continent and have concluded that past efforts to wage war against the virus have failed because:

- There was insufficient commitment and leadership to fight the epidemic among nations both inside and outside the continent;
- The war was being waged with too few human and financial resources;
- Programs that were effective, often undertaken by civil society organizations, were seldom scaled up and rarely expanded to national levels;
- Resources weren't reaching communities which have proven one of the most effective implementers of HIV-AIDS prevention, care and treatment and mitigation programs; and
- Programs were often too narrowly focused on the health sector.

A new strategy was developed by African countries and the donor community in the late 1990s to wage war more effectively based on:

- Defining national HIV-AIDS prevention, care and treatment, and mitigation strategies and implementation plans through a participatory and more comprehensive process (i.e. greater attention to a multi-sector approach and to gender issues, human rights, and the relationship between HIV/AIDS and poverty).
- Establishing National AIDS Councils as legal entities with broad stakeholder representation from the public and private sector and civil society, and with access to the highest levels of decision-making, including in government;
- Empowering and mobilizing stakeholders from the village to the national level with money and decision-making authority within a multi-sectoral framework; and
- Using *exceptional* implementation arrangements such as channeling money directly to communities and civil society organizations, and contracting services for many administrative functions such as financial management and procurement, monitoring and evaluation, elements of program approval, as well as capacity development and IEC/BCC.

The emphasis of the new approach, due to the nature of the epidemic, is on speed, scaling up existing programs, building capacity, "learning by doing" and continuous project rework, rather than on exhaustive up-front technical analysis of individual interventions. The new approach relies on immediate monitoring and evaluation (M&E) of programs to determine which activities are efficient and effective and should be expanded further and which are not and should be stopped or benefit from more capacity building. Funding "good" programs quickly is more important than funding "best practices" with delay which may result in even more HIV/AIDS victims.

The MAP approach represents the first phase of a 12-15 year World Bank program to support the national mobilization of Sub-Saharan African countries against the HIV/AIDS epidemic<sup>1</sup> In its design, the MAP is unprecedented in its flexibility and coverage. Country programs are designed to:

- Empower stakeholders with funding and decision-making authority;
- Involve actors at all levels, from individuals and villages to regions and central authorities;
- Provide support in the public and private sectors and in civil society; and
- Encompass all sectors and the full range of HIV/AIDS prevention, care and treatment, and mitigation activities.

<sup>1</sup> *Because mitigating the epidemic is a medium- to long-term challenge, the MAP will be phased over 12 to 15 years. Phase 1, over the first three to four years, would scale up existing programs in HIV/AIDS prevention, care and support, and mitigation and build capacity. Phase 2, following a rigorous stocktaking, would, over the next five years, mainstream those programs that have proved effective, attain nationwide coverage, and expand care, support and treatment interventions. Phase 3, by which time new infections are expected to decline, would permit a sharper focus of prevention on areas or groups where the spread of the epidemic continues. The number of AIDS cases will probably peak during Phase 3, requiring a maximum effort in care and support.*

This new approach is being supported by a number of donors, including bilateral agencies, regional development institutions, and the World Bank which is committing US\$1 billion through the Multi-Country HIV-AIDS Programs (MAP) for Africa<sup>2</sup>. So far, as Table 1.1 shows, 28 African countries and two regional programs have received US\$1,028.4 million within the MAP approach and MAP projects are being prepared in another ten countries and for regional programs.

**TABLE 1.1 – FUNDING APPROVED UNDER THE MAP**

(US\$ Millions)

COUNTRY	COMMITMENT
ABIDJÁN-LAGOS <sup>3</sup>	16.6
REGIONAL CAPACITY BUILDING NETWORK FOR HIV/AIDS PREVENTION CARE AND TREATMENTS (ARCAN) <sup>4</sup>	10.0
BENIN	23.0
BURKINA FASO	22.0
BURUNDI	36.0
CAMEROON	50.0
CAPE VERDE	9.0
CENTRAL AFRICAN REPUBLIC	17.0
CONGO - BRAZZAVILLE	19.0
DEMOCRATIC REPUBLIC OF CONGO	102.0
ERITREA	40.0
ETHIOPIA	59.7
GAMBIA	15.0
GHANA	25.0
GUINEA	20.3
GUINEA-BASSAU	7.0
KENYA	50.0
MADAGASCAR	20.0
MALAWI	35.0
MALI <sup>5</sup>	25.5
MAURITANIA	21.0
MOZAMBIQUE	55.0
NÍGER	25.0
NIGERIA	90.3
RWANDA	30.5
SENEGAL	30.0
SIERRA LEONE	15.0
TANZANIA	70.0
UGANDA	47.5
ZAMBIA	42.0
<b>TOTAL</b>	<b>1,028.4</b>

<sup>2</sup> In September, 2000, the Board of Directors approved the US\$500 million Multi-Country HIV/AIDS Program for Africa (MAP1) followed by another funding (MAP2) of the same amount in February 2002.

<sup>3</sup> Regional project for Nigeria, Benin, Cote de Ivorie, Ghana, Togo

<sup>4</sup> Negotiated but not yet approved for United Republic of Tanzania, Ethiopia and Kenya

<sup>5</sup> Negotiated but not yet approved





# Chapter 2

## Lessons Learned in Program Preparation and Implementation

### 1. Why is this chapter important?

The MAP approach is experimental and based on learning-while-doing. The past three years of project preparation and implementation have generated valuable lessons of experience. General lessons for future MAP projects and for enhancing the implementation of existing programs are provided in this chapter. Lessons on individual aspects are presented in the chapters that follow.

### 2. What are the most important elements of successful programs?

The initial experience with the MAP program, as well as investment projects generally, suggest the following aspects of preparation will help determine overall success:

- **Ownership/Champions**—The program has the commitment of all the major stakeholders in a country and continuing leadership from “champions”—institutions or individuals in the public and private sectors and civil society determined to make it work. Mechanisms are established to permit champions who supported program preparation to remain involved during implementation;
- **Capacity to Implement**—There are people and organizations with the ability to implement the program effectively, especially to scale up existing programs, or who can acquire the necessary skills to deal with higher levels of activities;
- **Clarity of Objectives**—The program has very clear goals that people understand and accept: win the war against HIV/AIDS by mobilizing every part of society to expand and improve prevention, care and support and mitigation programs;
- **Quality of Design**—The project activities identified will move the program toward its goals, and the roles and responsibilities of each implementing participant and their relationship to one another are clearly articulated;
- **Stakeholder Involvement**—The people groups, and institutions who benefit, who provide the services and who manage the project and the resources are all engaged in the preparation (and implementation) of the program; and
- **Readiness**—Important elements of the program are ready to be implemented as soon as the funds are available.

Experience suggests there are also several aspects of program implementation that will also contribute to successful outcomes (See also Chapter 25 on supervision):

- **Flexibility and adaptation**—The program is adjusted and “reworked” continuously to meet changing circumstances. The original design is a guide, not a blueprint;
- **Focus on the goals**—The objectives are always kept in mind when making decisions: how will this action help us achieve our purpose?

- **Monitoring and evaluation**—A good M&E system is essential to tell us how well the program is doing, where it is going and how it needs to be adjusted; and
- **Stakeholder involvement**—Involving the stakeholders is no less important in implementation than in the design. There must be an openness to innovation and non-traditional partners
- **Intense supervision** — The complexity, scope and “learning by doing” nature of the MAP approach requires more intense supervision both by countries and donors
- **Harmonization** – The more that donors agree to harmonize their procedures and work within a common framework, whether it is adopting the “Three Ones”<sup>6</sup> or actually “pooling” of funds, the better is the chance of achieving the most effective and efficient use of available resources and ensuring rapid action and result based management.

### 3. What are the specific lessons from the initial MAP projects that can help new operations and recommendations?

Experience with the initial MAP operations has generated useful lessons of what works and what can be improved. Consultations with National Aids Councils, NAC Secretariats, donors, technical organizations, governments, NGOs, the private sector and foundations have identified important lessons for the “next generation” of HIV/AIDS projects.

- The fundamentals are sound: the basic concept, design and structure of the MAP are appropriate. The MAP approach has already begun generating results. There has been an expanded effort and more resources for prevention, mitigation, care and treatment of HIV/AIDS, stronger partnerships, funds channeled directly to communities, faster project preparation and stronger implementation capacity. Basic strengths of the MAP approach include:
  - Reliance on existing programs
  - Flexible design adapted to local conditions
  - Mechanisms to channel support directly to civil society and communities
  - Multi-sectoral approach
  - Focus on partnerships
  - Speed of preparation
- Preparation and implementation need to be better in some basic ways. While the basics are in place and provide a good foundation for development of new operations, several aspects are not working well. Each bullet below identifies areas where MAP Projects can be designed and carried out better (roughly in order of their place in project processing):
  - Stakeholder involvement
  - Understanding the fundamental social factors
  - Thinking and acting differently
  - Getting started well
  - Scaling up and building capacity
  - Managing and monitoring the overall program
  - Sharing good practice, and
  - Working more effectively together.

<sup>6</sup> One agreed HIV-AIDS Action Framework that provides the basis for coordinating the work of all partners; One National AIDS Coordinating Authority, with a broad based multi-sectoral mandate; and One agreed country level Monitoring and Evaluation System.

**(i) Genuine stakeholder involvement in both preparation and implementation is fundamental to effective programs.** This is not just theory or theology; it is demonstrably true—programs are more effective when people living with AIDS, caretakers, health professionals, program managers, suppliers, civil society members and others touched by the disease are actively engaged in deciding what is to be done and ensuring that it is done. In practical terms, it means their participation in project planning (such as seminars on the “logical framework”), consultations on specific programs, involvement in the preparation of the Project Operations Manual, implementation of the monitoring and evaluation system and serving as watchdogs to ensure services are delivered. To date, there has been more rhetoric than substance on community engagement in particular. Genuine stakeholder participation is less time consuming than dealing with programs that fail because of its absence.

**(ii) Good social analysis is a prerequisite for behavioral change.** HIV/AIDS is a social disease, spread (and controlled) by behavior. A good social analysis is needed early in the project cycle of implementing agencies to identify the specific social conditions, values and norms that contribute to the spread of HIV/AIDS and affect its treatment and mitigation. Social analysis is not yet a routine part of preparation, but should be, especially for specific programs in prevention, care and mitigation and for monitoring and evaluation.

**(iii) Management of HIV/AIDS programs calls for exceptional measures.** It is not business as usual. The initial response to the MAP program in many countries has been to treat these projects as any other, when the urgency of the problem and its devastation call for unconventional responses. However, the National AIDS Councils (NAC) and the Secretariats (NAS) have been more effective where they see themselves as guides, facilitators and coordinators rather than traditional project “control” and implementation bureaucracies. Implementation of key aspects, including financial management, procurement, monitoring and evaluation and selected service delivery, have usually been more effective when they are “contracted” rather than done “in house.” This may be particularly important in getting started, using respected outside agencies to initiate an assessment of impacts and drafting an initial work plan.

**(iv) Start well, end well.** Experience suggests that projects succeed when implementation begins promptly as soon as funds become available. This helps show results quickly and builds and sustains commitment. The initial MAP projects have generally started slowly, with a loss of momentum and enthusiasm. This suggests completion of several preparatory activities before Credit funds are available as indicated in the Box 2.1;

**Box 2.1: Elements of Good Preparation**

- a) Preparation of the operational manuals and first year program,
- b) Piloting of expansion activities through retroactive financing or other means,
- c) First year performance targets,
- d) Developing mechanisms for advocacy “champions” to stay engaged during implementation,
- e) Assigning key responsibilities to the agencies already engaged, especially the Health Ministry, and
- f) Launching assessments of the impact of HIV/AIDS within ministries and beginning program development at the earliest stage. It may be possible to get started quickly by using project preparation funds (such as PHRD Grants), the IDA Project Preparation Facility (PPF) or a government’s own resources that may be reimbursed under the project (retroactive financing).

**(v) Scaling up existing programs and building capacity for HIV/AIDS activities have been tougher than originally expected.** The two major objectives for phase one of the MAP program are to (i) scale up existing HIV/AIDS programs and (ii) build capacity where needed to implement them, both in the public sector and civil society. This has been harder than envisaged. Capacity building needed for scaling up has two distinct components; (i) enhancing skills; and (ii) increasing the quantity of existing skills and institutional infrastructure. Donors are often more prepared to finance (i) rather than (ii).

The greatest challenge in the MAP approach is to fund on a sustained basis the increase in the quantity of African skills that already exists and the expansion of the institutional infrastructure, including incremental operating costs and logistics. Scaling up can be accelerated if the preparation process: (i) assesses the quality of existing programs; (ii) selects programs for support in the first year in a transparent process; and (iii) the NAS is empowered to approve programs quickly. Capacity building can also be accelerated if NASs contract with experienced local technical resource organizations to deliver training and if public sector agencies establish an AIDS coordination unit responsible for training. Capacity building and capacity enhancement is a continuous, never-ending process that needs full time attention. Civil society organizations need: (i) two to three year funding commitments to invest in “scaling up” their level of operations; and (ii) funding for administration and management as well as incremental operating costs such as personnel, equipment and materials and appropriate transportation.

Monitoring and evaluation systems are the key to effective implementation. In an experimental and learning process, a good M&E system is essential. You can't learn if you don't know where you are starting from and check periodically how you're doing against what you had planned. Most MAP projects do not yet have an effective system to measure progress and evaluate results. All of them should have them. (See Chapter 23). In addition, employing field investigators to visit a sample of beneficiary organizations to assess the efficiency, effectiveness and transparency of program implementation has proven useful in assessing impact and in publicizing the MAP program both nationally and internationally.

- (vi) **Successful programs draw on the experience of others**, benefiting from collaboration about “good practices.” “Knowledge management” about what works and why can facilitate effective program implementation, scaling up and capacity building. The experience and knowledge gained within a country and across countries can be shared by the creation (and external funding) of national Technical Resource Groups and specialized organizations, animated by the NASs and UNAIDS Theme Groups. The challenge is not to create new knowledge but to share existing, relevant knowledge more effectively among program coordinators and implementers, all of whom are overloaded with work and information.
- (vii) **Partnerships matter**: hang together or hang alone. Combating HIV/AIDS effectively can only be done by genuine collaboration—within government, between the public and private sectors and civil society, among citizens and with and among donors and specialized international agencies. Partnership involves sharing power and responsibility during program design and implementation, not always easy for organizations used to being dominant in their fields. (See Chapter 8 on Partnerships).
- (viii) **The value of multiple efforts**. Lessons from the private sector, especially companies dealing with consumers, teach that changing behavior requires that multiple messages, with different content, be sent through various media, with diverse sponsorship in order to affect the way individuals, families and communities act. In short, winning the war against HIV/AIDS requires multiple efforts. Young people about to embark on their first sexual encounters are a key target group of HIV/AIDS program. Changing their behavior is challenging and these people need to be reached through many different mechanisms – parents, peers, churches, schools, local government, cultural organizations, mass media of all kinds, etc. Sending messages to youth through all these mechanisms is not duplication, which is wasteful, but multiple efforts, which is effective.
- (ix) **The MAP is demand –driven**; this has resulted in more emphasis by implementing agencies on prevention and mitigation than on treatment. While this may change now that prices for ARVs have fallen sharply, it is now clear that treatment programs will require a massive international effort, especially to scale up programs as rapidly as required. To give an encouragement to treatment and to test different implementation models, the World Bank is providing US\$ 60 million in grants to partnerships of the public health sector and civil society in three African countries as

well as to WHO and UNECA for specialized support and knowledge sharing. In Burkina Faso, the partnership will focus on organizations of people living with AIDS, in Ghana with the private sector and in Mozambique with non-government organizations, including faith-based organizations.

- (x) The welcome reduction in the prices of ARVs means that substantially larger numbers of AIDS patients will receive treatment.** However, as drug prices have come down, the other costs associated with treatment – medical and support personnel, non-ARVs drugs, biological monitoring, etc. – have largely remained constant (See Table 2.1 below). Many of these treatment costs are local, not foreign, operating costs rather than investment, salaries rather than commodities – all areas that many donors traditionally have avoided funding, especially on a long term basis. While the MAP will finance all costs associated with treatment, this needs to be the norm among donors rather than the exception.

**Table 2.1**

Cost Category	Lowest Cost Scenario (US\$)	High Cost Scenario (US\$)
ARV Drugs	140	1,000
Other Drugs	80	80
Biological Monitoring	150	400
Personnel	200	200
Equipment	50	50
<b>Total Cost</b>	<b>620</b>	<b>1,730</b>







# Chapter 3

## Scaling Up

### Why Scaling up is Important?

The most important issue in the fight against HIV/AIDS is how to scale up existing programs that are only reaching small numbers of people to the national level and to build capacity for new programs which, having proven their efficiency and effectively, can also be expanded. Scaling up has become an important means of addressing the HIV/AIDS pandemic because;

- Organizations addressing the epidemic, especially in civil society but also in the public sector, lack scale and impact;
- HIV/AIDS program implementers are innovative and influential but may be reluctant or find it difficult to expand the scope and depth of their activities;
- The war against HIV/AIDS requires scaling up in volume and the kinds of services provided by all partners.
- Many effective programmes are remaining at the pilot scale and not taking advantage of the additional financial resources becoming available.
- HIV/AIDS lacks organizational / activity history – i.e. many of the the interventions (VCT, treatment programs etc.) may be new in a country and the mechanisms for coordination (i.e. NACs) are relatively recent. This is unlike other types of scaling up that have been talked about in the past like immunization, family planning, etc.

Scaling up can help to ensure the success of programs while they are rapidly expanding to meet the ever-increasing demands of affected communities. Scaling up is also an important consideration for treatment acceleration programs in order to expand effective programs to broader coverage. In view of limited resources, it is important to plan programs that reach as many of the targeted population as possible. Scaling up HIV/AIDS programs addresses issues like:

- Increasing access and demand;
- Improving quality;
- Reaching new target audiences;
- Introducing new technologies (e.g., prevention, antiretroviral therapy, etc.);
- Increasing/scaling up of coordination mechanisms to ensure coverage, prevent duplication and increase communication;
- Increasing M&E
- Expanding the capacity of institutions, both in terms of funding existing skill levels and resourcing the administrative/logistics infrastructure as well as upgrading skills levels if appropriate.

## 2. What is Scaling-up?

“Scaling-up” is the process of expanding the scale of activities and institutions with the ultimate objective of increasing the numbers of people reached and/or the impact on HIV/AIDS. Scaling up may entail; expanding coverage, altering the type or intensity of coverage, increasing impact or improving quality. While there is no precise definition, scaled-up programs usually reach (or provide access for) substantially more of the targeted population within a specified area.

### Today’s challenge is not only deciding what to scale up, but how, including:

- Assessing what systems, leadership, and investments are needed to shift from a random collection of organizations providing various services to address the HIV/AIDS epidemic to an integrated program capable of providing and sustaining services for an ever-increasing number of clients.
- Determining how to operate at program levels which requires strong local leadership and buy-in from diverse local stakeholders, development agencies, and donors who may think they have little in common with each other.
- To achieve credibility and sustainability, the program must be led by local partners (Public, NGO/FBO, CBO, etc) who have the authority and leadership to champion its development.
- Ensuring sustainable financial mechanisms for program support. There is considerable concern over scaling up when there is no assurance of medium and long term funding. This is a particular challenge where organizations are asked to undertake scaling up and yet only one year’s funding is assured. The reality is that just developing the organizational infrastructure can take many months, let alone the activities themselves.

### There are certain steps which need to be considered before scaling up;

- **Have a vision/plan to scale up from the beginning of the project**

From the start of a scaling up program, there should be a clear road map on how the specific approach could be expanded if it is successful. Adequate planning is an important component of the scaling up process. Policy support, leadership, networks, and funding all relate to the feasibility of “going to scale”. It is critical that all organizations and “players” who will be counted on to move the program to scale must be involved from the start to best support expansion efforts. The potential and possible steps for achieving the desired scale should be discussed and those responsible should be identified and provided with adequate time and resources to ensure that the required steps are followed. If the activity is designed a pilot or demonstration project it should also consider the requirements of translating such activities to broad scale during the planning phase.

- **Determine the effectiveness of the approach**

It is important to establish that the technical intervention, methodology or approach that is being considered for scaling up leads to desired results through carefully evaluated and documented monitoring and evaluation. The demand for innovative and new approaches to involving communities in improving their interventions is, in some cases, leading to scaling up some approaches too quickly, without proof that the new approaches really do improve programs or lead to other positive results.

- **Assess the potential to scale up**

Not all programs have the potential to scale up, or at least not in their existing form. It is important to assess the possibilities for scaling up and the potential barriers.

- **Build a consensus to scale up**

Building consensus for scaling up among decision makers, implementers and leaders of those who participate in the program is very important. The proposed interventions should be introduced and the case for its added value to key individuals and groups should be presented clearly to assure their buy in.

- **Advocate for supportive policies**

Before expanding a HIV/AIDS scaling up program, the existing policies in the country should be evaluated to determine whether they present barriers to effective large-scale program implementation.

- **Secure comprehensive funding**

The amount of funding needed for large-scale programs is often not available through only one donor. Or, only a “package” of donor financing will assure full financial coverage, including the funding of operating costs, especially salaries, logistics, administration, etc. There may be a need to negotiate contracts, budgets, and work plans with a number of technical partners and donors.

- **Establish and maintain a monitoring and evaluation system**

National HIV/AIDS programs implementers need to meet regularly at the local, regional and national levels to monitor progress, identify problems, develop innovative solutions, strengthen skills and build teams. It is important to establish participatory systems that provide for regular monitoring of process and outcome indicators. Instruments and tools to help program teams monitor their progress should be developed and used to synthesize information and detect trends over time which will feed in to the future scaling up program planning and implementation review.

- **Support institutional development for scale**

For community action to be sustained over the long term on a larger scale, it needs to depend not on individuals but on organizations and/or networks dedicated to HIV/AIDS.

### 3. Lessons Learned and Recommendations

- Scaling up involves expanding institutions as well as expanding programs. Expanding institutions require up-front investments in administrative and fiduciary infrastructure, increased staff, mobility and logistics levels, etc before direct program funding can be used. Scaling up institutions requires donors to be prepared to fund local costs and operating costs, including salaries for the medium to long term rather than on a “declining” basis. Scaling up should not be started unless external funders are prepared to maintain their institutional support for the long term, especially in the resource poor countries that are particularly affected by HIV-AIDS.
- To scale up successfully, program management and coordination systems must be carefully designed so that information, human and financial resources can be used most effectively to reach greater numbers of the target population. And partnerships and networks providing the infrastructure support and leadership for going to scale should be involved from the beginning of programs design and planning.
- Programs intended for scaling-up should be pilot, evaluated and assessed to determine whether expansion is feasible. This should also include detailed cost estimates.
- Learning from experience. Any effort to achieve scale and increase the range of services available will benefit from hard-won “lessons learned” elsewhere. Knowledge transfer should support learning from experience, especially in the dynamic environment surrounding the HIV/AIDS epidemic. New technologies and networks are now available to create communities and practices around critical areas. The scaling-up framework should include a learning framework that will help structure knowledge to be applied to problems encountered during scale-up.

- In order to scale up district level programs to national levels; governments, multilateral institutions and bilateral donors should be willing to empower communities and local and sectoral HIV/AIDS committees with financial resources and enlist those people who have successfully implemented the small scale programs to train and guide the larger numbers of locally credible volunteers needed to reach the entire population.
- Training and technical assistance in successful program methodologies must be provided to larger population and IEC campaigns should be used to spread the methodology, tools and lessons learned on a regional, national or international level. A nationwide small team can be established that will provide technical assistance and training to other organizations or communities that choose to scale up their programs.

**Box 3.1: Having a very good understanding of what needs to be scaled up is very important for successful programs**

In 2002, the Federal Government of Nigeria decided to scale up the ARV treatment program. The take off was very slow because there was no concurrent scale up of VCT. However, once the program got going, the demand was huge, and at the end of 2003 drugs ran out, and the quality of the program in some places was very poor. ARV drugs are now back in the health facilities, but some patients were without drugs for three months. There were a number of lessons learned for scaling up. Most importantly the 'package' that is being scaled up needs to be clearly defined. In this case, drugs were scaled up without the prior scaling up of VCT, logistics management (supply chain etc) training of health personnel, treatment of OIs, laboratory services and M&E systems. This story tells us that despite the good intentions of scaling up treatment programs, if poorly managed scaling up may lead to long term damage such as treatment resistance and program credibility.

- Working with communities/organizations which have participated in the successful initial pilot scaling up sites to establish them as "living universities" where others who want to learn the methodology can go to get hands-on training and field experience.
- Spread the use of successful methods and tools through regional or international workshops/conferences. Training tools can be introduced at workshops where participants can practice using them. Support groups of trainees can be established so that they can learn from each other's experiences and provide assistance with common issues.
- Develop mechanisms to aid communities that are interested in replicating or adapting the methodology or using the tools that are already proven to be successful.<sup>7</sup>
- Look beyond linear or one-on-one partnerships. Inter-organizational learning involves not only sharing each other's special skills, but also the pool of technical resources that may be made available through established networks.
- Consider scaling up HIV/AIDS activities first within organizations that already have existing infrastructure and coverage. For example, faith based organizations have enormous reach/coverage.

Invest and maintain continuous M&E and good program supervision. Scaling up is about "learning by doing" which requires a willingness and capacity to redesign, adjust and be flexible continuously.

<sup>7</sup> Contact information at the end of the television or radio programs or print stories can lead the audience to a web site or contact address for more information to share lessons learned.

# PART II



Project Description





# Chapter 4

## Project Description

### 1. Introduction

This section is a bookmark - a reminder that the Project Implementation and Operational Manual, which is a part of MAP project preparation, contains a description of the MAP Project. As the Manual is often the principal guide to implementation for most stakeholders, the Project Description needs to be clear and concise. It should contain a description of the project components<sup>8</sup>, costs and the expected results.

**In MAP, country projects will typically include some version of the following components:**

- **Building capacity of government agencies and civil society:** To enhance the capacity of the public and private sectors and civil society to implement a broad range of HIV/AIDS activities. This includes particular focus on strengthening national HIV/AIDS councils and their secretariats, line ministries (other than Health), Ministry of Health, as well as capacity building for NGOs and Community Based Organizations (CBOs) at local levels.
- **Expanding the public service response:** To support government's response to HIV/AIDS in a broad range of sectors, with particular attention to strengthening health systems. Resources will flow to sector ministries and other government agencies to carry out sector HIV/AIDS programs against agreed targets and timetables. Given the overarching importance of the Ministry of Health in HIV/AIDS for clinical services, surveillance and procurement of medical equipment and supplies (including drugs, condoms, test kits, syringes, etc.), it may be appropriate to have a specific project component to build the capacity of the MOH and fund its HIV/AIDS activities
- **Focusing on civil society organizations and communities:** To establish an emergency HIV/AIDS Fund to channel grant resources directly to civil society and community organizations, including NGOs, groups of People Living with HIV/AIDS (PLWHA) and the private sector for local HIV/AIDS initiatives. These typically operate from a Special Account separate from the public sector special account and disburse on the basis of plans developed by local stakeholders.
- **Project Coordination:** To ensure effective project coordination, facilitation, monitoring and evaluation. This includes development of common management systems and establishment of knowledge sharing networks within and among countries. To maintain the concept of "coordination," many aspects of project implementation can be contracted to other public and private sector and civil society organizations.

See Annex 4 (CD-ROM) for further references

<sup>8</sup> MAP programs do not contain a list of what can be funded (a positive list) but a list of what can not be funded (a negative list) is generally restricted to large buildings and weapons.







# Chapter 5

## Project Readiness Checklist

### 1. Introduction

Project readiness is key to successful project implementation. Projects that start up promptly after funds are available are much more likely to be implemented efficiently and effectively. Lessons from MAP projects highlight the need to have essential analyses, designs, organizational aspects, staffing and implementation, financial management and procurement and monitoring and evaluation plans in place prior to funding approval.

The objective of the checklist is to ensure that effective project implementation can commence immediately after funding approval. This means there will be few, if any, conditions of project effectiveness. The table on the following page identifies the most important aspects of the project that should be ready when the project commences. The milestones represent major decision points within the World Bank approval process (see next page).

### 2. Lessons learned and recommendations

- Project implementation delays are almost always directly linked to inadequate project preparation
- Clear communications among stakeholders is a key to success during project preparation and implementation
- Stakeholders, including development partners, need to participate in project design and preparation and those involved in preparation should remain involved in implementation. In addition to having a basic right to be involved in decisions concerning their future, project implementation is enhanced by this participation
- Fiduciary architecture and essential manuals need to be developed with and tested by key implementation stakeholders
- Clear institutional arrangements and Terms of Reference for different important posts and responsibilities should be agreed during preparation; this can be facilitated by institutional assessments, especially for communities and civil society stakeholders. The capacity of implementing agencies needs to be carefully assessed and capacity improvement measures built into project design, especially with regard to financial and progress reporting and documentation
- Availability of first year programs for both public and civil society organizations accelerates overall MAP implementation
- Recruit NAS staff early and from diverse sources, especially from the private sector and civil society organizations and from the public service outside the Ministry of Health. This should be done transparently using a competitive process to ensure quality and objectivity
- Implementing agencies need to prepare a social impact assessment when they are preparing their programs
- The provision of a PPF (Project Preparation Facility) is important to pilot activities and accelerate project effectiveness

Table 5.1 - MAP-Project Readiness Checklist<sup>9</sup>

Key Project Preparation Elements		Milestones for Readiness		
		By Appraisal	By Negotiation	By Board Approval
1	Letter of commitment and policy from government received and NAC established at start of project preparation. REQUIREMENT			
2	National HIV/AIDS strategic plan that reflects a multi-sectoral approach to be in place and adopted by NAC. REQUIREMENT	Adopted		
3	NAS established and NAC Councilors or / Commissioners and the NAS Director appointed by preparation. REQUIREMENT	TOR of professionals agreed, office established.	Other key staff appointed and office established	Remaining staff selected and appointed
4	Key NAS staff trained in procurement, financial management, & monitoring & evaluation as required. REQUIREMENT	Training plan established	Training of key staff begun	
5	Operations Manuals, Project Implementation Plan (PIP) and First Year Procurement Plan (PP) developed including detailed implementation schedule, and detailed budget plan (and local budget), and required TOR. REQUIREMENT	Draft Operations Manuals, PIP and PP discussed	Final documents agreed	Operations manuals, PIP & PP issued
6	Operations manual prepared. REQUIREMENT	Draft document	Final document agreed	
7	Medical Waste Management Assessment. REQUIREMENT	Completed		
8	Operations to be contracted (eg, financial management, procurement, procurement audit, internal audit, M & E, community mobilization, technical evaluation of grant proposals, capacity building) agreed. REQUIREMENT	Agreement reached between government and donor and TOR approved	Pre-qualification and shortlist completed	Contractors appointed
9	Appointment of mandatory external auditor. REQUIREMENT	Agreement reached between government and donor and TOR approved	Pre-qualification and shortlist completed	Auditor appointed
10	Institutional Assessment. REQUIREMENT	Completed		
11	Training plan prepared for general NAS staff and other institutions and communities. DESIRABLE		Draft plan discussed	Agreed
12	Financial management, procurement & monitoring & evaluation system established at NAS. REQUIREMENT	Requirements determined	Hardware and software in place	Systems functional
13	Bidding documents for 1st year of project prepared. Documents issued after effectiveness. REQUIREMENT			Bid packages, standard bid documents discussed and agreed
14	Special Account opened and local funds available. REQUIREMENT		Accounts opened and funded.	
15	Preparation of first year programs for public agencies and of initial civil society program submissions, including social assessments by implementing agencies. HIGHLY DESIRABLE	Draft	Final document agreed	NAC approval

<sup>9</sup> Checklist assumes that: (a) there will be few, if any, conditions of effectiveness; and (b) the agreed period for fulfilling the Readiness Checklist tasks is realistic. Funds to undertake the tasks noted in the Checklist are available from sources such as PHRD grants, PPF funds, grants from other donors, and counterpart funds.



# Chapter 6

## Medical Waste Management

### 1. Why is attention to the environment important?

The principal natural and potentially adverse environmental consequence of HIV/AIDS programs is the proliferation of contaminated medical waste. The diagnosis of medical conditions, care of people infected with HIV/AIDS or other sexually transmitted diseases will require the use of reagents, needles, gloves, drugs, and other pharmaceutical supplies. Inappropriate handling and disposal of medical waste and inadequate management of the respective disposal sites in urban and peri-urban areas, where domestic and medical waste may be mixed, and where scavenging is a livelihood, is likely to have negative environmental and social impacts.

### 2. What needs to be done?

Given these potential consequences, the preparation of MAP projects now includes a Medical Waste Management Plan, because:

- Inappropriate handling of medical waste materials constitutes a risk not only for staff in hospitals and in municipalities who are involved in waste handling, but also for families and street children who live on or near dump sites
- Some aspects of the proposed project implementation (e.g., the establishment of testing clinics, the purchasing of equipment by communities for home care of the sick, etc.) could constitute an increase in the environmental and social risk with regard to the handling of HIV/AIDS infected waste

#### **Box 6.1 Specific groups to be consulted during the preparation of the Medical Waste Management Plan can include:**

- The national association of PLWHAs and affected families
- The implicated sectoral ministries (i.e. Environment/National Resources and Urban Planning; Public Works and Transport; Social Protection; Tourism)
- Managers/owners of private companies subcontracted for municipal waste collection and disposal
- Public Health personnel responsible for oversight of the hospital and health facility clinical waste management
- The manufacturers of the locally constructed

#### **To deal with the problem of hazardous waste, MAP projects normally include the following:**

- Construction plans and equipment for new health facilities, at all levels of service provision, must include capacity for sound handling and disposal of hazardous hospital waste. This should comprise the requisite human resource capacity devolved to management and disposal function of infectious medical waste, as well as the availability of cost-effective and environmentally and socially proven technologies.

- Monitoring and evaluation indicators will be established following completion of the Medical Waste Management Assessment for inclusion in the appropriate category (i.e. social mobilization, care and support, policy) in the common M&E project manual

### 3. Lessons learned and recommendations

While it is too early to draw definitive lessons of experience, there are a number of areas that warrant attention:

- **Projects should provide systematic training and capacity building** (on the subject of HIV/AIDS waste management) of all health personnel responsible for managing existing incineration and waste management units in medical facilities.
- **Medical Waste Management Plans should normally**
  - Assess a country's legal framework pertaining to medical waste management and treatment as well as the need for additional regulatory requirements;
  - Collect baseline data on current technologies, management practices and institutional setup collecting, handling and disposing off medical waste in the country;
  - Assess environmental and social impacts of current management practices;
  - Assess alternative technologies and facility sizes for treatment and destruction; Analyze available information on existing disposal sites;
  - Assess the potential of the private sector as service provider, as well as public-private partnerships and cost recovery; and
  - Prepare a training needs assessment for municipal workers and managers, MOH staff, scavenging families and the general public directed at building a national consensus on the economic benefits of good medical waste management
  - Propose institutional arrangements for sound implementation and monitoring of the plan, with clear lines of the responsibility of the various actors involved and an implementation schedule; and
  - Present detailed cost outlays for the various mitigation measures, to include awareness and capacity building activities and the monitoring plan.
- **A well targeted awareness building campaign program** can be created for the general public and more specifically for health care workers, municipal workers, dump site managers, incinerator operators, nurses, scavengers and street children.



See Annex 6 (CD-ROM) for further references

# PART III



Institutional Arrangements





# Chapter 7

## Role of NAC and NAS

### 1. Why is this chapter important?

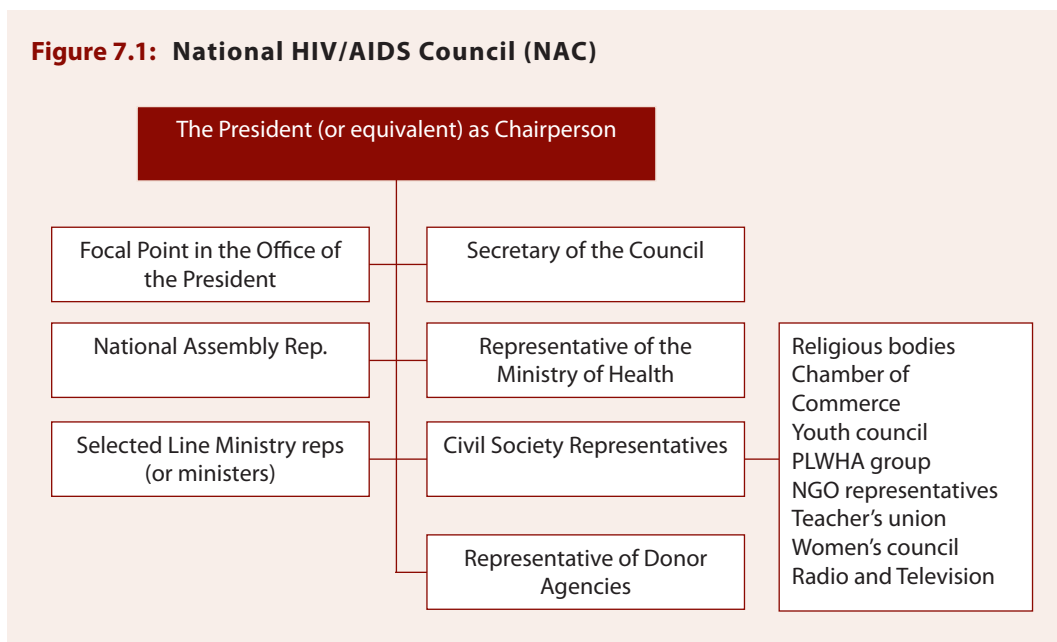
To participate in the MAP, every country has established a high-level HIV/AIDS coordinating body with broad stakeholder representatives and developed a strategic, multi-sectoral approach to HIV/AIDS. Creating a high-level body has been relatively straightforward. Defining its role and making it operational have been more difficult. Similarly, national policies and strategies have been drafted, but translating these principles into an implementation program empowering implementing agencies from the village to the nation has proven to be a major challenge.

This chapter offers practical suggestions on the role for a National AIDS Council (NAC) and the National AIDS Secretariat (NAS), and their roles in converting the strategy into concrete project implementation.

### 2. What are the typical roles of the NAC and its Secretariat?

#### (a) The role of the National AIDS Council (NAC)

In each MAP country, a high-level body has been created to oversee the national multi-sectoral HIV/AIDS program. The NAC includes representation from all principal stakeholders concerned with the epidemic--public sector organizations, private business, NGOs, FBOs, CBOs, people living with HIV/AIDS—and headed by the head of state, prime minister or other senior public official above the ministerial rank. (See Figure 7.1.)

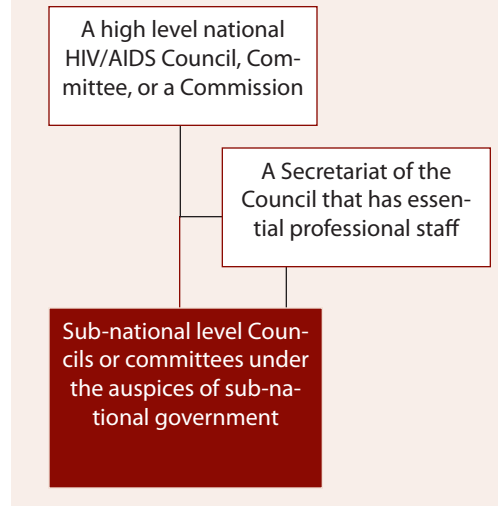




In principle, NACs are responsible for: (i) guiding the elaboration, approval, and revision of the national HIV/AIDS strategy and action plan, (ii) defining policies, (iii) approving large projects with a national scope, (iv) reviewing and approving annual work programs and global budgets, (v) reviewing progress in the implementation of the program, and (vi) serving as the lead advocate for attention to the HIV/AIDS epidemic

In reality, its role is often ill-defined. The Council may meet regularly but infrequently, particularly if chaired by the President or the Prime Minister, and its members may have little training in their responsibilities. Most NACs have not yet played a role in approval of programs or oversight of the MAP itself. In most countries, NACs are supported by a Technical Advisory Committee that provides advice on professional matters.

Figure 7.2

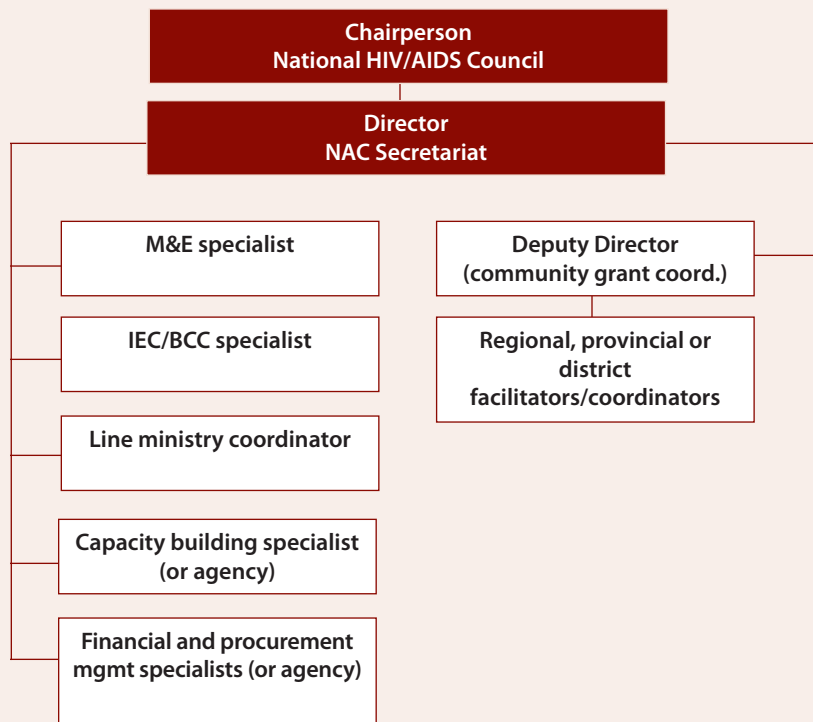


**(b) The role of the secretariat supporting the NAC (NAS)**

The NAC is served by a secretariat or a coordinating unit (in some countries it is a special secretariat<sup>10</sup> within a Ministry, or a separate Project Coordination Unit<sup>11</sup>) responsible for the day-to-day business of the national HIV/AIDS program, the “NAS”. From country to country NAS takes different forms, uses different nomenclature, and has different responsibilities.

Assuming NAC is chaired by the head of state or prime minister, NAS operates under their offices. NAS is composed of a limited core staff which manages contracting services for both administrative and programmatic aspects, and is complemented by sectoral focal points (see Figure 7.3). Generally NAS is the principal administrative and technical support to the National HIV/AIDS Council and is the main coordinator and facilitator of the national multisectoral HIV/AIDS program, whether funded by the World Bank or other donors. The NAS is typically responsible for: (i) supporting multi-sectoral HIV/AIDS program planning and implementation, training, research, monitoring and evaluation; (ii) stimulating HIV/AIDS responses within line ministries as well as at sub-national levels (regional, district, municipalities), NGOs and other partners so as

Figure 7.3: Illustrative NAS Structure and Staffing



Role of NAC and NAS

<sup>10</sup> For example Mozambique

<sup>11</sup> For example Uganda

to enhance coordination; (iii) reviewing annual work plans and budgets developed by ministries, regions, and municipalities for presentation and approval by the NAC; (iv) managing the national HIV/AIDS program in accordance with an administrative, financial, and procurement operations manual; (v) monitoring and evaluating HIV/AIDS programs at all levels; (vi) compiling and providing regular reports to the NAC (whether monthly/quarterly/annual); and (vii) liaising with donors.

For both the NAC and the NAS the critical task is to monitor and evaluate the national response. The contribution of a strong M&E effort cannot be under-emphasized and needs to be underscored regularly. Chapters 23-24 treat M&E and social impact monitoring in detail.

### 3. NAC/NAS and the Country Coordination Mechanism

In some countries where NAC/NAS is established and has sufficient management capacity, it also carries out the responsibilities as the Country Coordination Mechanism for the Global Fund against HIV/AIDS, TB and Malaria (GFATM) (for example The Gambia). In another case, for example in Angola (under preparation) CCM is going to be responsible for the oversight role of the MAP support.

Such arrangements ensure that the government institutions are not over burdened with unnecessary coordination responsibilities to achieve the same objectives.

### 4. Lessons learned and recommendations

- **NAS can sometimes become a bottleneck to effective activity implementation.** The intent of the MAP approach was to have a “light” unit in the NAS which would guide programs and facilitate implementation, contracting services for many of its specialized activities. The basic rule is that NAS should only have the minimum staff it needs to manage contracting services. In reality, some NAS units are emerging as government bureaucracies, creating “in-house” capacity and “empowering” themselves rather than empowering implementing agencies in ministries, civil society and communities. Some NAS themselves as implementation units with “command and control” authority. Also, in some countries the entire MOH staff dealing with HIV/AIDS was moved to the NAS, thereby weakening the health sector and diminishing the multi-sectoral nature of the NAS. The tendency of some NASs to move from “coordination and facilitation” to “command and control” may represent the single greatest danger for the national multi-sectoral HIV/AIDS program to implement rapid and sustainable action. This tendency can be avoided by:
  - Contracting services to carry out functions such as financial management, procurement, M&E, IEC/BCC, capacity development, and elements of program approval and disbursement of funds. Experience indicates contracting services is more efficient and effective than NAS staffing itself to perform such functions;
  - Close oversight of the national response by the NAC, with annual work programs, service standards and performance reviews for NAS and its staff;
  - NAS staff need to be few in number but highly qualified and recruited not only from the public service but also from the private sector and civil society. NAS staffing should not result in weakening the already limited capacity of the Ministry of Health to carry out its functions;
  - Secondment of private sector and NGO staff to the NAS for high-priority activities; and
  - Separating the two key functional areas of the NAC and NAS: (i) Program aspects including preparation, approval and coordination, monitoring and evaluation, advocacy. (ii) Program administration - the actual disbursement of funds, financial management, procurement. All program administration and many program aspects can be provided by contracted services from the public or private sector so that NAC does not become a cumbersome bureaucracy.

- **Contracting for services is both efficient and effective.** As HIV/AIDS overwhelms public systems, contracting for services is a way of bringing in reinforcements. By involving more people and organizations in the struggle, it reduces the work that any one of them has to bear. It also builds interest within the private sector to engage more closely in addressing HIV/AIDS. It is, therefore, desirable in and of itself. It also provides several functional advantages:
  - Contracting promotes an efficient division of labor. Many tasks are so specialized or repetitive that they are best carried out by entities that have developed expertise in them. Most of these having nothing to do with HIV/AIDS; they include such detailed (and mundane) tasks as collecting program data, financial management and procurement. Delegating this work to those who know it best liberates public officials to perform the HIV/AIDS-specific functions that they alone can fulfill (such as setting policy).
  - Private contracting of such services also tends to be less expensive. Competition in tendering will produce the best available price, and in the course of the contract the firm will look for the most cost-effective means of fulfilling its obligations.
  - NAS officials sometimes fear that contracting for services will mean a loss of control. In fact, the opposite is true. Contracting actually increases NAS's control. When a NAS purchases services from a contractor, it can specify in the contract precisely the nature, level, mix, and standards of services it expects. The contractor has an incentive to perform well, both to ensure renewal of the contract and to enhance its commercial reputation, given the high profile of national HIV/AIDS programs. If the contractor fails to perform, it can be held legally compelled for any resulting delay or damages, and NAS can terminate the contract. By contrast, when a NAS depends on public sector providers, there are generally no service standards, and NAS has neither legal recourse for substandard performance nor authority to terminate the provider. Given the rigidity of most civil service systems, this leaves NAS at the mercy of a single provider.
- **NAC should be a national, multisectoral, multi-stakeholder body, located at the highest executive level of Government, endorsed by the legislative branch.** Given the developmental nature of the HIV/AIDS problem, NAC ownership should be cross-sectoral, inclusive rather than exclusive. NAC should be the channel for donor and other partner dialogue and commitment. NAC composition, size and functions will reflect the country's situation but in any case should be located in the highest government level which can provide the necessary authority and sustained commitment to action to carry out a successful program.
- **NAC must have a clear mandate to function effectively.** NAC and its supporting secretariat (NAS), must have their roles, functions and responsibilities well defined. This is particularly important with respect to any coordinating functions, and the relationship with focal points (especially line ministry focal points who represent their Ministers). The effectiveness of NAC is widely perceived to rest more on its advocacy<sup>12</sup>, policy, resource mobilization, and monitoring functions than on direct intervention. NAC/NAS mandates and priorities must be clear so that partner agencies in both the public and private sector and civil society understand, cooperate, and support NAC/NAS. To be credible and effective NAC members will need to devote time to capacity building and training. This is not always easy given the high level positions and standing of NAC representatives. In some countries such as Kenya, NACs have established sub-committees to focus on specific aspects of the MAP program, as indicated in Box 7.1.

**Box 7.1: NAC Sub-Committees**

In Kenya the National AIDS Council has established sub-committees to handle specific responsibilities, each headed by a specialist (such as the representative of the private sector on finance):

- Finance
- Monitoring and evaluation
- Program management
- Institution building

In addition, it has created a National Executive that acts on behalf of the NAC between meetings.

<sup>12</sup> NACs often hire specialized firms to establish and operate a communications strategy both for advocacy and to publicize the many HIV/AIDS activities that can be, or are, funded.

- **Training needs of NAS and implementing entities need to be better focused and coordinated.** In contrast to the lack of training for NAC representatives, there has often been too much “training” of NAS staff from a myriad of donor and technical agencies. The training has not always been focused on the right issues. NAS ought to have a systematic and coordinated training program for itself and its associated implementation entities, focused on: (i) facilitation, coordination and communication skills; (ii) updated technical knowledge on HIV/AIDS prevention, care and support and impact mitigation; (iii) management skills, including developing realistic work plans, financial management and computer skills; and (iv) monitoring and evaluation.
- **Work programming needs to be stronger.** One of the most difficult tasks of project management is to translate strategies and plans into effective action. NAS units are charged with the responsibility to coordinate the development and aggregation of annual work plans from cooperating agencies. While criteria for project selection have been developed, they are not always shared with ministerial focal points. In the future, arguably the single-most important role for a NAS will be to develop an integrated, fully-costed annual project implementation plan for approval by the NAC, with clear definition of responsibilities, outputs and budgets.
- **Contracting of services should be the rule.** The goal of having a “light” NAS structure and avoiding a new bureaucratic structure will only be accomplished with extensive contracting of services, rather than expanding NAS permanent staff. This is true for both administrative and technical responsibilities.



See Annex 7 (CD-ROM) for further references





# Chapter 8

## Partnership

### 1. External partnership

The first phase of the MAP approach emphasizes scaling up existing programs, building capacity in African countries, and engaging all potential stakeholders. Many external partners have been supporting African HIV/AIDS programs for years with both funding and technical advice; the MAP aims to build on, or help expand, those programs—not to supplant or compete with them. Consequently, all stages of MAP preparation and implementation involve other relevant actors in a number of different ways, including external partners.

External partners in the war against HIV/AIDS in Africa include:

- Major providers of funding such as the Global Fund for AIDS, TB and Malaria (GFATM), bilateral donors, regional financial institutions, and multilateral institutions.
- Suppliers of technical expertise such as specialized agencies of the United Nations, national organizations, and independent entities.
- International NGOs and institutions that specialize in HIV/AIDS prevention, care and treatment and mitigation programs and research.
- Non-traditional development partners, such as faith-based organizations, traditional authorities, and affected private sector enterprises (see Box 8.1), that are often in the forefront of the war against HIV/AIDS and can reach larger audiences.

Partner arrangements range from limited (the simple exchange of information on what individual partners are doing) to the extensive (the sharing of money and decision-making, as in “joint” program funding and “pooling” arrangements).

### 2. External partnerships are involved in MAP operations in different ways at different stages:

- **Program Coordination.** The National AIDS Councils are expected to coordinate the activities of the implementing agencies in both the public sector and civil society. They are also supposed to coordinate the contributions of the various donors, with facilitation support from UNAIDS. UN Theme Groups at the country level are attended by the heads of international and bilateral agencies to enhance program coordination within the donor community;
- **Joint/Complementary Preparation.** The expertise and experience of various agencies in the HIV/AIDS epidemic are increasingly applied in preparing MAP country projects. Access to grant resources under the Japanese PHRD Trust Fund has been important in the preparation of MAP operations, as has assistance from UN agencies and bilaterals. UNAIDS plays a key role in helping support such multilateral collaboration.

- **Complementary/Parallel/Joint Financing.** MAP funding is only one of a number of sources of financing and technical assistance, each contributing to the effective implementation of a national HIV/AIDS strategy. The UK Department for International Development (DFID) is assisting in the expansion of the district response initiative to access funds in Cameroon, Kenya and Nigeria. Several donors, such as UN agencies, (GFATM), Agence Francaise de Developpement, the United States Agency for International Development, the Netherlands, German Agency for Technical Cooperation (GTZ), European Union (EU), Canadian International Development Agency (CIDA), foundations such as Gates, and others contribute to the strengthening and implementation of National HIV/AIDS programs. The Clinton Foundation is working to lower drugs prices and to encourage additional funds from donors above their regular bilateral and multilateral funding levels to increase access to treatment;
- **Joint/Complementary Implementation.** There are several examples of countries which draw on the comparative advantage of various agencies as they scale up or replicate implementation of programs. These include: monitoring and evaluation and technical resource networks with UNAIDS; surveillance and coordination with Ministries of Health with the World Health Organization (WHO); youth and PMTCT initiatives with the United Nations Children’s Fund (UNICEF); refugee/migration activities with UNHCR and IOM; human rights and workplace interventions with the International Labor Organization (ILO); capacity building for communities and faith-based institutions with USAID, the United Nations Development Program (UNDP) and other organizations; inventory and logistics system with the Governments of Japan and India; and Italy is active in supporting the establishment of blood supply, among other areas.
- **Harmonization** – The more that donors agree to harmonize their procedures and work within a common framework, the better. In this regard, adopting the “Three Ones” will enhance the chance of achieving the most effective and efficient use of available resources and ensuring rapid action and result based management.

  - One agreed HIV-AIDS Action Framework that provides the basis for coordinating the work of all partners;
  - One National AIDS Coordinating Authority, with a broad based multi-sectoral mandate;
  - One agreed country level Monitoring and Evaluation System

**Box 8.1: Partnership in Supervision**

The first formal supervision mission for the Ethiopia MAP country project was an example of partnership among donors and UN agencies. Dividing the supervision mission in five areas of focus, the partners shared the supervision effort as follows:

Supervision Focus	Institutional Responsibility
1.Capacity Building	CRDA, Netherlands, UNAIDS, UNICEF, USAID, World Bank
2.Public Sector Response	ILO, UNDP, WHO, World Bank
3.Civil Society Response	World Bank
4.Project Coordination	UNAIDS, World Bank
5.Financial Management & Procurement	World Bank

- **Pooling of Funds.** The most extreme and effective partnership is the “pooling” of funds by donors. In the case of Malawi, for example, a number of donors and the World Bank have agreed to “pool” their funds in one account. Following agreement each year with Government on the annual work plan and outputs, a detailed financing plan is agreed identifying which activities will be funded by “earmarked” donors, those who provide funds individually, and by “pooled” donors, those who provide general program funding in a common account that is available to finance any eligible program expenditures.
- **Joint Supervision.** Joint supervision of national HIV/AIDS programs, led by NAC and involving all active external partners, is the best way to ensure focused and coordinated support. However, coordination should be ongoing through out the year, and not take place only during periodic reviews.

### 3. Lessons learned and recommendations

- **Stronger Partnership is Better.** Experience from all MAP countries shows that when external partners agree on intensive and extensive partnership arrangements, the MAP countries benefit from a more focused framework and a more effective and efficient utilization of scarce financial and human resources; Recommendation: Strong partnership among external partners is best served by all the partners participating in joint annual reviews of the national HIV/AIDS program, led by the NAC/NAS and the implementing agencies (i) at the end of the fiscal year to assess past performance and makes recommendations for program improvement; and (ii) half way through the fiscal year to assess the next year’s program and make financial commitments. In some cases, countries have decided to combine (i) and (ii) but in other cases the benefit of having two assessments annually, at least initially, is felt to be important. The annual review is described in more detail in Chapter 25 on supervision. “Pooling” of funds is another example of strong partnership.

#### Box 8.2 Using Technical Resource Networks to Enhance Program Implementation

There exists in Africa and elsewhere a wealth of technical expertise and practical experience that can be brought to bear on national HIV/AIDS programs, and made available to all levels in countries. Experts need to be selected for their outstanding knowledge and practical expertise in a range of technical fields and form flexible technical resource networks (TRN) in such areas as: social mobilisation; Information, Education and Communication (IEC); Voluntary Counselling and Testing (VCT); home-based and community care; biological and behavioural surveillance; prevention and treatment of sexually transmitted infections (STI); social marketing; tuberculosis (TB) control; and process skills such as rapid participatory assessment methods, management information systems, conflict resolution and management skills, monitoring and evaluation, social assessment and social impact monitoring

The establishment of TRNs is an integral part of using knowledge management and partnership as essential tools in social and intellectual mobilization against HIV/AIDS. Experience suggests that line agencies using staff technical services is not without its difficulties. Potential users of technical expertise need to know such services are in fact available. They must become critical and effective demanders of specialized technical services. On the supply side, the NAC/NAS and selected TRNs will need to be proactive in promoting the availability of such services, especially until implementing agencies develop the habit of integrating external services.

For such a dynamic to get established, two things need to occur: (a) A core minimum of TRNs need to be established early.



- **Lack of regular partnership can lead to conflicting messages to NACs, inefficient allocation of resources, and impede national program implementation.** In one country with insufficient partnership coordination, one donor offering technical assistance sent a mission to establish in-house NAC M&E capacity while the major funding donor was urging contracting M&E. In another country, a log frame workshop initiated by one donor was followed the next week by a workshop on indicators sponsored by another donor. **Recommendations:** (i) NACs should establish the capacity to manage overall relations with external partners and support the commitment to having One national coordination authority; and (ii) all donors should use the UNAIDS Theme Group as a monthly forum for exchanging information and views among themselves and with the NAC. Even where NAC is weak in coordinating donors, the donors bear a responsibility to ensure they are not working at cross-purposes or leaving important gaps;
- **Technical Resource Networks (TRN).** In a number of countries, external partners have decided to establish TRNs in areas where a concentrated approach is appropriate, as outlined in the following box:

### Box 8.3 Advantages of Engaging Faith Based Organizations

Religious organizations and FBOs have a 2,000 year history of working within local communities and helping them to resolve their problems - HIV/AIDS is just the most current concern. In Africa, faith groups have provided 30-50% of all the hospital beds available in the countries. With the commitment of the donor community to stay in the fight against HIV/AIDS for the long-haul, religious organizations and FBOs are good partners because they have a similar commitment to stay in the communities even when others have moved on to a new agenda. The MAP program already recognizes that the keys to having an impact against the epidemic are partnership and having a comprehensive response, with each player/actor bringing the best resources in its arsenal to the table. FBOs have all the beneficial criteria that CSOs have (see Chapter 6) but they also possess the moral authority to influence behavior change, have access to a broad audience on a regular basis, have greater grassroots involvement, and a holistic approach to the epidemic in providing both physical, psychosocial, and spiritual solace. The MAP program supports such a holistic approach in community responses and therefore should be better integrated into the work of the FBOs.

Engaging religious bodies and FBOs in the national response to HIV/AIDS can lead to greater influence on behavior and social justice. For instance, the UNAIDS Best Practices study of the Islamic Medical Association of Uganda (IMAU) shows that AIDS prevention activities carried out through religious leaders had a significant, direct impact on the epidemic in Uganda. In fact, Uganda provides a specific example of how partnership with religious bodies can have a great impact; the involvement of FBOs and religious leaders in the national response to HIV/AIDS was a deliberate national policy institutionalized within the NAC, so that the national response was enhanced by the messages of fidelity and abstinence from the Anglican, Catholic and Muslim leaders who all supported President Museveni's inclusive approach. Just as the MAP has a lot to learn from FBOs in reaching local communities, FBOs can also learn from the MAP. The availability of networks for implementing agencies that the MAP promotes can be helpful in sharing implementation lessons, as well as providing opportunities to identify areas where there are gaps. In particular, the establishment of networks of inter-religious councils and associations in several African countries has helped to identify the critical obstacles that FBOs face in accessing resources from the MAPs, their areas of similarity and complementarity, and new ways in which they can work together to assist their constituent communities. There are also disadvantages to be aware of in partnering with FBOs: although they have the greatest reach to communities, FBOs are sometimes reluctant to deal with the issue of condom usage and prevention messages may be limited to abstinence messages. MAP funding does not define which is the correct message but should try to include all messages on prevention and encourage FBOs to either promote condom usage when necessary or to refrain from making comments on condom usage. In addition, FBOs are often not accustomed to providing financial and programming reports like other CSOs and NGOs, so it is challenging to institute the financial accountability that is crucial to further MAP funding and an extra effort must be made to develop this capacity, such as the recent hosting of FBO workshops in Addis Ababa (May 2003) and Accra (January 2004).

**Box 8.4 Examples of Successful Faith-Based Organizations Programs Against HIV/AIDS****Matthew 25 House**

A Catholic Pastoral Outreach Center that does HIV/AIDS outreach and support activities for PLWHAs in *Koforidua* in the *Eastern Region* of Ghana. Founded by Rev. Bobby Benson, the center provides a haven for PLWHAs to receive care and support from laity chaplains and obtain mutual support through various avenues:

- **A Clinical Pastoral Education program** that trains ordinary men and women over one year in four units of three months duration each. The chaplains receive information on HIV/AIDS and are empowered to go and educate the public, and to reach out to and care for PLWHAs through one-on-one counseling and home visitation.
- **A PLWHA support group** has grown from 8 in 1999 to about 60 members in 2003, who meet fortnightly to discuss concerns and obtain counseling, mutual support, and treatment for opportunistic infections.
- **Identification of orphans in need of support** for school uniforms, fees, shoes or sandals, stationery and school bags. Needy orphans are identified either by dependents of the members of the PLWHA support group or by members of the communities where the PLWHAs are visited. 112 orphans have been identified to 50 are receiving support for school fees and uniforms.
- **Outreach activities** to better educate the municipal communities on HIV/AIDS and reduce the stigma and discrimination experienced by PLWHAs.
- **YOUTH ALIVE clubs** created to **provide reproductive health education to the youth** in the regional schools through peer counselors who receive three weeks of intensive training on HIV/AIDS. The clubs allow youth to obtain accurate information on HIV from their peers, who also serve as role models, and they are accompanied by PLWHAs who describe their experiences firsthand and relate that HIV can infect anyone.

GARFUND, the civil society fund in Ghana, approved a GHC 220 million sub-project for orphan support and care and support activities that has been an important source of funding for the Matthew 25 House activities.





# Chapter 9

## Capacity assessment of civil society organizations

### 1. Introduction

The challenge of assessing CSO's capacity for effective scaling-up of activities to deliver/implement national HIV/AIDS program objectives is recognized to be a key challenge in National HIV/AIDS Program (NAP) implementation. There are a variety of CSO's with different sizes, capacity, knowledge, skills, and geographic coverage which are responding to the HIV/AIDS endemic. The capacity assessment is at two levels: (a) the overall national capacity of CSO's to deliver/implement NAP objectives; and (b) individual CSO assessment to obtain grant funding from the NAP.

This chapter deals with CSO capacity assessment needs, methodologies and suggests essential assessment aspects from MAP experience. There are a number of CSO (NGO/CBO) assessment toolkits developed by various organizations that are available on the internet. This chapter does not recreate anything new but reproduces what seems most relevant for a HIV/AIDS program.

### 2. Why CSO assessment is important?

The need for CSO capacity assessment is important to:

- Determine a country's overall implementation capacity;
- Assess to what extent scaling-up of HIV/AIDS initiatives can be realistically pursued in a country;
- Help in planning realistic policies, strategies and plans to enhance a country's response to HIV/AIDS in partnership with CSOs;
- Develop practical working relationships with CSOs in fight against HIV/AIDS from the community to the national levels;
- Determine individual CSO's capacity at the time of their request for grant financing from the MAP (and other) sources of funds. This is to ensure that the CSO can deliver the outputs and outcomes needed for the HIV/AIDS programs in a transparent and accountable fashion; and
- Mobilize as many resources as possible to generate a rapid response against the epidemic.

### 3. What type of CSOs and the levels of assessment ?

- **Types of CSOs and the levels of assessment.** It is necessary to understand the types of CSOs in a country and their basic characteristics and the level of assessment required under a NAP. The following table illustrates these aspects as experienced under the MAP:

Table 9.1

Types of CSOs	Basic characteristics	Level of assessment required
Grassroots level community group.	<ul style="list-style-type: none"> <li>The leader is usually the community head or the religious leader of the community.</li> <li>The group has some knowledge of delivering community based activity(ies).</li> <li>Has access to people who can read, write and can maintain basic cash-in and cash-out registers.</li> </ul>	<ul style="list-style-type: none"> <li>A sample of such groups should be included in the national assessment.</li> <li>Basic assessment is required to determine if they can undertake HIV/AIDS initiatives on a limited scale at the time of applying for the funds.</li> </ul>
Community Based Organization. including Special interest group (women, youth, CSW etc)	<ul style="list-style-type: none"> <li>Has a formal management structure (usually 3+ people).</li> <li>Covers well identified target locations, or 1-5 villages or small population clusters.</li> <li>Has some knowledge of accounting requirements and usually has access to a fulltime or part-time accountant or a bookkeeper.</li> <li>Has basic knowledge of HIV/AIDS related issues, community mobilization, community based development.</li> </ul>	<ul style="list-style-type: none"> <li>A sample of such CBOs needs to be included in the national assessment.</li> <li>Assessment at the time of grant application to include: past experience in implementing social development activities; knowledge of HIV/AIDS and related challenges; acceptability by the communities (community leaders) they cover; fiduciary management capacity.</li> </ul>
Local NGO	<ul style="list-style-type: none"> <li>Has a formal management structure (usually 10+ people).</li> <li>Covers more villages or population clusters.</li> <li>Has satisfactory knowledge of accounting requirements and has access to a fulltime or part-time accountant.</li> <li>Has general knowledge of HIV/AIDS related issues and community mobilization, community based development, monitoring and evaluation requirements.</li> <li>Is currently receiving funds (not necessarily for HIV/AIDS) from bigger NGOs (local or international), donors or the government.</li> </ul>	<ul style="list-style-type: none"> <li>A sample of such LNGOs needs to be included in the national assessment.</li> <li>Assessment at the time of grant application to include: past experience in implementing social development activities; HIV/AIDS activities, knowledge of HIV/AIDS and related challenges; acceptability by the communities covered; fiduciary management capacity including past financial statements; monitoring &amp; evaluation knowledge and practice; established office place with consumables, equipment and having a regular operating budget, ability to mobilize additional funds and a strategy for scaling up HIV/AIDS activities.</li> </ul>
International NGO	<ul style="list-style-type: none"> <li>Has a formal management structure including technical and administrative staff.</li> <li>Has established accounting procedures per international standards.</li> <li>Covers a number of population clusters.</li> <li>Has thorough knowledge of HIV/AIDS related issues, community mobilization, community based development, monitoring and evaluation requirements.</li> <li>Have considerable years of experience in the county (or internationally) in the areas of basic health care and/or HIV/AIDS.</li> </ul>	<ul style="list-style-type: none"> <li>A sample of such LNGOs needs to be included in the national assessment.</li> <li>Assessment at the time of grant application to include: past experience in implementing social development activities; HIV/AIDS activities, knowledge of HIV/AIDS and related challenges; acceptability by the communities (community leaders) covered; fiduciary management capacity; monitoring and evaluation knowledge and practice; established office with consumables, equipment and having a regular budget.</li> </ul>

**When to assess?** There are two instances when CSO capacity assessment is required: (a) During project preparation, an overall assessment is required to establish a country's capacity in delivering an HIV/AIDS program. At this stage, an appropriate sample of community groups, CBOs, FBOs, LNGOs, and NGOs should be selected and an overall assessment should be done<sup>13</sup>; and (b) Every applicant to access funds from the NAP needs to be assessed by the NAC/NAS (or its authorized entity, such as a program management agent) to determine if the applicant has satisfactory knowledge and capacity to deliver what they are proposing.

<sup>13</sup> This assessment not only provides information on what is required to scale up CSO operations but what kind of fiduciary architecture – financial management and disbursement, procurement and program monitoring and evaluation – is appropriate, relevant, effective and efficient.

**Project preparation stage**

(a) *What to assess? Approaches for both cases are different, a broader assessment is needed to establish overall country's capacity:*

- Geographic area covered, type (table 9.1), experience in HIV/AIDS or basic health care areas, budget & sources of funding, staffing, beneficiaries being served, type of subprojects being implemented or experienced;
- HIV/AIDS awareness in the CSO staff;
- Attention to gender issues, community ownership;
- Community participation in project design/development, and that it addresses matters raised by the community;
- Relationship with public-sector counterparts and relevant donors;
- Planning, administration and project management capacity;
- Financial management, procurement management capacity – sustainability, experience and weaknesses;
- Program monitoring and evaluation capacity;

(b) *What to deduce from assessment?*

- Generic capacity weaknesses and activities to mitigate capacity risks;
- Assessment criteria for the NAP grant applicants;
- M&E requirements;
- Sub-grant application process(es);
- Contracting out options for subproject appraisal, review, supervision, fiduciary management, fiduciary advisory services for CSOs;
- Whether the community has been involved in the design of the project, and whether it addresses concerns raised by the community;
- Levels of government and non-government mechanisms to get resources to the CSOs as swiftly as possible;
- Capacity building plan with cost estimates and strategy for implementation; and
- Defining the scope of the MAP.

**Sub-grant proposal application stage**

(a) *What to assess? Specific, case-by-case assessment of individual CSOs at the time of applying for MAP funds. Such assessment generally include:*

- **General.** Legal status, office/field office locations and geographic area covered, type (table 9.1), infrastructure, budget & sources of funding, staffing, beneficiaries being served, type of subprojects being implemented or experienced;
- **Institutional.** Includes experience in HIV/AIDS and/or basic health-care areas and/or community mobilization and capacity building areas; staff and their HIV/AIDS awareness and training levels; relationship with the public-sector counterparts and relevant donors; planning, administration and project management capacity; monitoring and reporting capacity; legal dispute or debts which could materially affect CSOs'ability to undertake the subproject;
- **Coherence.** Understanding of problems and their causes, understanding of the technical issues; adequacy of activities proposed in subproject proposal; rationality of outcome/outputs indicators; budget and its reasonability for the proposed activities; understanding and adequacy of monitoring plan; adequacy of personnel/resources to monitor the implementation; and innovative or creativeness;
- **Fiduciary.** Financial management and disbursement, procurement management capacity in terms of staffing (or access to); record keeping; accessibility to banking services; relevance of activities and expenditure items; and reporting;

- **Sustainability.** Community participation in proposal preparation; implementation maximizing on existing experience, knowledge and/or skills (and of the local community); strategy to sustain operational/maintenance costs once implementation is complete; role of women in the community/subproject and the impact it will have;
- **Social.** Attention to gender issues, community ownership; understanding of community characteristics (ethnic/cultural, socio-economic, main sources of income, literacy, health status, etc.); good understanding of the people and community; recognition of the concerns of women, youth, the elderly and other vulnerable groups; community participation; risks from the local groups or institutions which may pose an obstacle to the success of the initiative.

*(b) What to deduct from assessment?*

- Generic capacity weaknesses and activities to mitigate capacity risks proposed and included in the CSO's proposal;
- Relevance of activities proposed to existing capacity and knowledge;
- Establish scope of proposed activities and relevant budget;
- Establish program M&E requirements based on proposal duration and output indicators;
- Establish essential capacity building needs and inclusion in the capacity building plan of the NAC/NAS;
- Determine association with other experienced CSO for implementation support, fiduciary support and capacity building;

#### 4. Lessons learned

- **Overall country level CSO assessments have not been comprehensive.** Some assessments done during MAP preparations are either too detailed in some areas but not comprehensive or lack important dimensions. The overall assessments generally do not have the right mix of different CSOs;
- **There is a shortage of relevant professionals** to conduct such assessments. It is an appropriate investment to hire local consultants to perform this work;
- **It is not necessary but a template approach would be useful** to determine a country's CSO capacity.
- **At the subproject appraisal level,** not all applicants are equally assessed. In some MAP countries there are too many levels involved in assessing the same CSO that takes an unnecessarily long time and discourages the CSOs.

In some MAP countries the CSO assessment is so casual that implementation becomes a problem. In some cases, the communities have not been sufficiently involved in the project design, and the implementing partner has developed the project without a real project proposal. An assessment can detect such cases.



# Chapter 10

## Civil Society Organizations

### 1. Introduction

Civil Society Organizations (CSOs) represent a wide range of actors outside government and the for-profit sector, including national and international non-government organizations (NGOs), faith-based organizations (FBOs), professional associations, trade unions, PLWHA groups and community-based organizations (CBOs). They range from national level organizations such as major NGOs or professional organizations to grassroots groups, such as women's savings clubs.

### 2. Why are CSOs important?

CSOs play a vital role in HIV/AIDS programs for the following reasons:

- **Governments alone cannot succeed against HIV/AIDS.** There is consensus that the factors that determine HIV transmission are often outside the influence of governments. Especially where cultural values and community norms are of critical importance, CSOs have a vital role to play in prevention but also in care, treatment and mitigation activities;
- **Public sector fully extended.** Public capacity to respond to AIDS is already fully extended and cannot meet societies' escalating prevention, care and coping needs, without extensive CSO involvement;
- **Rapid Response.** CSOs can often respond more rapidly than other agencies.
- **Sharing the burden.** CSOs may help to protect public sector health and social services becoming overburdened by HIV/AIDS;
- **Crisis response.** The scale of the HIV/AIDS crisis necessitates the fullest possible CSO involvement at all levels. Most people with HIV infection or illness already receive most of their support and care from the community not from formal institutions. Only through community involvement can programs of sufficient number, scope, coverage and value for resources and effort be achieved. Yet there is discontinuity between formal and informal responses that has not been adequately addressed. Formal responses seldom reach or provide appropriate support to community initiatives and communities are seldom able to access formal support;
- **Increasing community ownership.** CSO involvement leads to increased community ownership, leadership and management of HIV/AIDS responses;
- **Sensitivity of HIV/AIDS.** Because of the intimate, personal and sensitive nature of HIV/AIDS, most prevention, care and support and mitigation responses are best addressed through local, community initiatives;
- **"Contextualized" response.** The highly specific, localized context in which HIV transmission occurs, and in which prevention, care and coping responses are mounted, necessitates a wide range of locally defined, socially "contextualized", community initiatives;
- **Reaching the poorest and hardest to reach.** CSOs are able to provide training and resources to the poorest and most marginalized members of society, including hidden, marginal or under-served communities. Ensuring that training and resources reach such people is a cardinal goal of the MAP approach;
- **Value.** CSO responses represent an economical and effective way of reaching and serving large numbers of beneficiaries. Numerous community health activities illustrate that resources focused directly at community level can have far greater value than comparable resources directed to formal structures;



- **Innovation.** CSOs often develop innovative and cost-effective HIV/AIDS responses; and
- **Impact.** Evidence of declining HIV infection among young girls in Uganda and Zambia is widely attributed to changes in community norms brought about by CSOs, which led to behavioral change at the community level.

### 3. What role do CSOs play?

#### What are the major kinds of CSOs?

It is helpful to distinguish at least four different kinds of CSOs recognizing that some CSOs may belong to more than one category:

- **Non-government organizations (NGOs).** NGOs are usually formally registered organizations, with a formal structure, including a membership, board members and paid staff. They are typically required to submit periodic progress reports and audited financial statements to a parent ministry (or the donor), so they have at least some financial management capacity. There is also considerable variability: from local NGOs operating in defined geographic areas, to national NGOs, with a national presence, to international NGOs with thousands of staff operating in many countries. Financial management capacity, human resources and programming experience typically increase as one moves from local through national to international organizations. NGOs may also be classified by thematic focus, as, for example, development, human rights, environment or health NGOs. Many NGOs have considerable scope to add or mainstream HIV/AIDS within their existing activities. AIDS Service Organizations (ASOs) represent a specialized category of NGOs, focusing specifically on HIV/AIDS prevention, care and support and mitigation responses.
- **Professional associations and trade unions.** These are vocational associations, whose members form associations or unions to advance their occupational interests, typically by setting occupational standards, providing accreditation, negotiating compensation and developing a public position on matters of common interest. Examples include associations of lawyers, accountants, teachers and nurses or unions for transport, construction or agricultural workers. Nearly all formal sector employees are represented by one or more associations or unions. Their great strength is the size of their membership. For example, the Kenya National Union of Teachers (KNUT) has approximately 200,000 members. Most associations or unions have paid staff and at least some financial management capacity. They represent a greatly underused and promising channel to reach thousands of employees and their families in all sectors and levels of employment.
- **Faith-based organizations (FBOs).** These are religious affinity groups, including Christian, Independent, Islamic, Hindu, Judaic, traditional and other faiths. Although their primary aim is to provide spiritual teaching and guidance, most are enjoined by faith to undertake a social mission which includes teaching, care and welfare. Before the development of the modern administrative state in the last century, FBOs were virtually the only providers of education, care and social welfare services in many areas. They continue to play an important role. They range from national level institutions, with a central secretariat and significant financial management capacity, such as the Catholic Church, to independent, grassroots religious communities, with limited administrative experience. They have many important strengths: a strong commitment to education, care and social service; numerous adherents, particularly in the developing world; and unrivalled rural reach. Many have an umbrella structure, in which local religious communities, such as parishes, are linked to provincial structures, such as dioceses, which in turn are linked to a national secretariat. There is thus great scope to channel resources and training through a national secretariat to an entire province or country.
- **Community-based organizations (CBOs).** These are typically grassroots membership organizations, often without a formal structure or registration. They are remarkably diverse. Examples include informal traders' associations, farmers clubs, savings groups, sports clubs, PLWHA groups and local youth groups. Whereas many NGOs serve communities, CBOs are themselves drawn from and representative of their communities. They represent both implementation channels and beneficiaries. Whereas NGOs are often valued for their flexibility and professional skills, CBOs are valued because they usually directly represent the ultimate beneficiaries. Because CBOs may lack formal structures and financial management systems, it is important either to link

them to NGOs or to develop simplified financial management systems, typically limited to a committee, a bank account, a cash book and a file of receipts (See Chapter 13). Many HIV/AIDS programs try to build partnerships between NGOs and CBOs. NGOs provide resources, simple systems, training and support to CBOs. There is great scope to increase support to CBOs by developing simplified financial management procedures, designed specifically for CBOs and by promoting mentoring partnerships between NGOs and CBOs.

**What activities do CSOs undertake?**

CSOs play a leading role in changing cultural values and community norms and in assisting community support, care and mitigation responses. These strengths are evidenced in the following tabular summary of CSO HIV/AIDS activities.

**Table 10.1 - CSO HIV/AIDS Activities**

Activity	NGOs	Associations/ Unions	FBOs	CBOs
<b>Advocacy:</b>				
Advocacy	CSOs, such as PLWHAs groups have a major role to play in advocacy to improve HIV/AIDS response			
Training	CSOs play a major role in training			
<b>Prevention:</b>				
Mass communication	CSOs have role to play in promoting discussion of mass media campaigns			
Behavior change communication	CSOs have an important role to play in promoting behavior change communication and supporting peer education			
Condom distribution and promotion	Larger CSOs such as national reproductive health NGOs may promote and distribute condoms, often through downstream CBO networks			
STI care	Larger NGOs with health facilities may provide limited STI care, but NGOs are not optimal channels for STI care		FBOs with mission hospitals offer STI care.	CBOs may promote STI care seeking behavior.
HIV counseling and testing	NGOs may operate VCT centers, especially nested in multi-purpose drop-in centers	Other CSOs may play important role in promoting VCT. For example, FBOs may promote sexual deferral and couple based HIV counseling and testing before marriage as an effective HIV prevention strategy. CSOs also play a vital referral role, providing counseling and support and care to both HIV-positive and HIV-negative clients		
Blood safety	Large NGOs, such as the Red Cross, may operate blood safety programs in some countries	Other CSOs may play an important role in developing blood donor networks		
Prevention of mother-to-child transmission	Some CSOs such as FBOs managing hospitals may deliver ARVs to prevent mother to child transmission. Many CSOs have a major role to play in promoting services and providing referral services, particularly counseling and support to HIV-positive mothers and AIDS care to sick mothers and children identified during testing			
<b>Care Support and Mitigation:</b>				
PLWHA support	Many NGOs parent CBO PLWHA support groups, providing funding, administrative and technical support	Professional associations and trade unions have major roles to play in protecting rights of PLWHA	Many FBOs also parent CBO PLWA support groups, provide funding, administrative and technical support	PLWHAs are important CBOs, often linked to NGOs or FBOs, play a major role in providing care and support
Clinical AIDS care	Larger NGOs with health facilities may provide clinical AIDS care	Professional associations and trade unions have important roles to play in lobbying for care for members	FBOs with mission hospitals are important source of clinical AIDS care	CBOs play advocacy role, lobbying for improved AIDS care
Community, home based, AIDS care Orphans and vulnerable children	NGOs, CBOs and in particular, FBOs, play a leading role in community home-based AIDS care and support for orphans and vulnerable children			

## CSO program activity monitoring

Monitoring is essential, and CSO program activity monitoring should be as simple as possible. Each CSO partner will typically agree its key targets with the NAC/NAS and its decentralized structures, using the Planning, Monitoring and Evaluation Form contained in Appendix 5 of the UNAIDS/World Bank National Aids Councils (NAC) Monitoring And Evaluation (M&E) Operational Manual. Each CSO partner will then report results regularly using the Planning, Monitoring and Evaluation Form. These results will be checked and verified at least every six months by the designated monitoring agency. The designated monitoring agency will assess each CSO partner's progress towards targets every six months and rate their progress using the Planning, Monitoring and Evaluation Form. The designated agency will collate, analyze and submit to NAC summary reports of aggregate CSO activities every six months, using a simple, structured Progress Report Form. NAC and key CSO stakeholders will meet every six months to review M&E reports, to identify key lessons learned and to make strategic recommendations and decisions. NAC and key CSO stakeholders will update their M&E manuals and procedures based on lessons learned. Significant investment in capacity building is urgently needed to equip CSOs at all levels to undertake program activity monitoring.

## What are the major indicators of CSO performance?

Indicators should be relevant and as simple as possible. Illustrative indicators to assess progress in scaling up programs for major CSO activities are presented below:

**Table 10.2 - CSO Indicators**

<b>CSO Capacity</b>
Number of civil society organizations receiving NAC funding
Percentage of overall funding granted to civil society services
Number of new civil society partners introduced to HIV/AIDS programming with NAC support
Total AIDS services delivered by civil society
Number and estimated percent of orphan boys/girls receiving support for school fees
<b>CSO Services</b>
<b>Communication</b>
Number of (a) media HIV/AIDS radio/television programs produced and (b) number of hours aired
Number of HIV/AIDS prevention brochures/booklets (a) developed and (b) numbers distributed
<b>Prevention</b>
Number of (a) HIV prevention staff and (b) volunteers trained
Number of (a) HIV prevention meetings held and (b) men/women reached
Number of condoms sold/distributed
Number of men/women receiving STI care from health facilities with trained staff and uninterrupted supply of drugs
Number and percent of men/women receiving HIV testing and counselling
Number and (b) percent of women tested and receiving PMCT if HIV-positive (in rare instances where CSOs deliver PMCT)
<b>Care and Support</b>
Number of care (a) staff and (b) volunteers trained
Number of PLWHA support groups and (a) number and (b) percent of men/women enrolled
Number of (a) community AIDS care projects and (b) number and (c) percent of men/women enrolled
Number of (a) community orphan support projects and (b) number and (c) estimated percent of orphan boys/girls enrolled
Input Level (Deliver Personnel, Training, Equipment and Funds)
Paid staff, volunteers recruited, training conducted, equipment and resources provided

## 4. Financial management

There is likely to be very significant capacity differences among organizations which make up civil society, especially with regard to financial management and disbursement. It will, therefore, be very important from the outset to evaluate the financial management capacity of the civil society organizations which will request MAP funding. Financial management is particularly important because one of the fundamental aims of the MAP approach is to move funds to beneficiaries as fast as possible. The need for careful assessment, training, and effective systems is also highlighted by the fact that many civil society organizations will be implementing sub-projects on behalf of NAC/NAS as well as supervising projects at community levels and managing their funding requirements. Detailed information on financial management systems (FMS), and disbursement is located in Chapter 19 and Chapter 20 respectively. A summary of key guidelines follows:

- FMS of civil society must complement those of the NAC/NAS so that all project accounts can be consolidated and prepared efficiently;
- Standard historical cost accounting and other international accounting procedures apply to civil society FMS;
- Specific arrangements may be made between civil society and the NAC/NAS for payment of large accounts but in general civil society organizations will operate project bank account/s which will be replenished according to a prearranged formulae and the preparation and presentation to NAC/NAS of prescribed financial and physical reports;
- All civil society organizations participating in the NAC should be subject to an annual internal audit review; and
- A full annual audit of civil society organizations should take place if the organization is disbursing more than \$50,000 per annum. Organizations disbursing less than this should be subject to a random audit check.

## 5. Procurement Management

Generally, the same procurement procedures are to be followed by the CSOs (especially the NGOs and the private sector) as by the NAC/NAS. However, this will largely depend on the financial value of the goods, and services to be procured under an agreement between NAC/NAS and a CSO. Chapter 21 provides descriptions of procurement methods, procedures and the process.

On the other hand, CSOs including smaller civil society groups, associations etc., would use Simplified Procurement Procedures agreed between the government and the donors during project appraisal. Chapter 21 provides relevant procurement information for such organizations. A summary of key guidelines follows:

- CSOs will follow a simplified procurement procedures as agreed with NAC/NAS (within the government rules agreed with the donors during project preparation);
- They will prepare a procurement plan showing what is going to be procured, in what quantity, at what estimated price, from where and when;
- They will adopt a clear and transparent process to acquire quotations award contracts to local suppliers;
- All CSOs will maintain records and receipts of all items/services procured and submit to NAC/NAS (or its authorized entity) when requested;
- All CSOs will form a purchase evaluation committee within their organization which would evaluate received quotes and award the contract.

## 6. Lessons learned and recommendations

- **Accessing MAP funds should be simple, transparent and effective.** Applications forms for civil society organizations to request funding under MAP programs need to be extremely simple to elicit the required information without burdening the CSO. The essence of the application form will include: what is to be funded, for whom, with what stakeholder involvement, with what objective, and with what fiduciary architecture.
- **Documenting CSO expenditures should be simplified.** Once a CSO receives funding, documenting the use of the funds to allow for further funding from the NAC and between the NAC and the donor should be simplified. The CSO should be heavily involved in determining what “simplified” means since central organizations tend to require too much information that is too costly to produce and often irrelevant.
- **CSOs need comprehensive funding, including for administrative and operating costs, for several years in order to invest in scaling up.** Unlike public sector agencies that usually budget on an annual basis, CSOs need to increase their size in order to scale up, a process that requires investment in administrative capacity, people, equipment and facilities. Funding of administrative overhead, including transportation and other business logistics, additional personnel and training, and incremental operating costs are inherent expenses of scaling up that should be funded by national HIV/AIDS programs. Most CSOs require a funding commitment of two to three years in order to make the commitment to scaling up. Investments in administrative overhead and infrastructure needed in scaling up are often front-loaded in the first year;
- **Concept of a CSO Umbrella Body or Facilitating Agent.** Some MAP countries are trying to accelerate the access of civil society organizations to funding and to learn a number of important lessons. National umbrella organizations may play an important facilitation role. Large, or otherwise experienced and relatively well-endowed NGOs can also serve as mentors and facilitators to small NGOs and CBOs in both organizational formulation and planning for scaling up. An example of the role of a facilitating agency in Ethiopia is presented in Box 10.1 below

### Box 10.1: The Role of Facilitating Agencies in Building Civil Society Capacity

ACCORD is an international NGO that has worked in Ethiopia since 1986. It currently works in four areas of Ethiopia: Addis, Dire Darwa, Gambella and Shashemene, primarily in urban and rural livelihoods and community capacity building. ACCORD has an intensive CBO capacity building program in Addis, elements of which are infused into ACCORD’s work in other regions. ACCORD’s CBO program aims to promote the role of traditional CBOs (Edirs) as grassroots partners through three components: advocacy, direct financial support and training. The program has served to increase CBO networking and confidence to access resources and take up diverse development activities. A UNAIDS/WorldBank team visited ACCORD and CBO partners in Shashemene and observed that simple project management and financial administration systems shared by ACCORD had genuinely taken root in CBOs. CBOs visited had membership records, simple numbered receipts and informal cash books provided by ACCORD. They used training and planning systems shared by ACCORD. Their records were simple, clear and up-to-date. ACCORD’s support has significantly increased the capacity of community organizations to apply for, receive, manage, program and account for EMSAP resources.

- **Capacity building of CSOs.** Some MAP projects have not started systematic programs of building capacity in civil society. There is a need to identify capacity needs and contract technical resource organizations or groups with clear capacity building experience and performance targets to undertake, in partnership with local organizations, training on and exposure to national and international good practices for HIV/AIDS program activities;

- **Importance of horizontal learning networks.** Lessons of experience indicate that CSOs learn best through informal horizontal learning networks, in which CSOs undertake site visits to established projects, organize internships or placements with skilled CSO staff, build coaching and mentoring partnerships between experienced and new projects and develop local learning networks, where geographically proximate CSOs meet regularly to address and resolve issues of common concern. Investing in these kinds of learning may appear expensive at first but have large pay-offs in the speed and quality of project implementation;
- **Existence of a wealth of technical expertise.** There exist nationally and internationally a wealth of technical expertise and practical experience that needs to be brought to bear on national HIV/AIDS programs, and made available in all sectors and levels of countries. Technical expertise and practical experience range from IEC, VCT, home-based and community care, biological and behavioral surveillance, prevention and treatment of STI, social marketing, TB control and process skills such as rapid participatory assessment methods, social assessment, managing information systems, conflict resolution and management skills and M&E;
- **“Civil Society Review Board”:** While CSOs are almost always well represented on National AIDS Councils, NACs are mostly involved in areas of strategy development and mono-program review. CSOs have the interest and the technical capacity to help ensure that HIV/AIDS programs perform up to expectations. The joint UNAIDS/World Bank MAP progress report in 2001 recommended that countries may wish to consider creation of “Civil Society Review Board” (CSRB) made of acknowledged HIV/AIDS advocates that should represent such important constituencies such as PLWHA, trade unions, religious organizations, human rights and women organizations, the media, and the private sector. The CSRB should be mandated to review the rate and amount of fund disbursement against targets, the impartiality, objectivity and quality of grant making and overall MAP performance. The CSRB should have a full time coordinator with an operating budget to develop effective linkages with all stakeholders;
- **Piloting scaling up.** To scale up existing programs in civil society it is important to: (i) pilot the scaling up of program funding; (ii) contract “Technical Support Agents” to facilitate program preparation for small and medium sized NGOs and for community-based organizations; and (iii) consider re-imburement to NGOs for eligible expenditures ( to be defined ) by ex-post examination and re-imburement dating back to the date of completion of appraisal as a measure to provide working capital to NGOs which can scale up quickly.
- **Don’t ration funding.** On occasion the demands from NGOs will be larger than the indicative funding available. In view of additional resources available from a variety of donors, including MAP, funding to CSOs should not be rationed.



See Annex 10 (CD-ROM) for further references





# Chapter 11

## Communities

### 1. Introduction

The previous chapter on civil society examined organizations of varying degrees of complexity, ranging from highly organized NGOs to relatively informal CBOs. The civil society chapter focused on reaching communities primarily through intermediaries, such as NGOs, FBOs and CBOs. It described how NGOs and FBOs often work with downstream CBOs, providing funding and technical support to CBOs, which in turn provide services to communities. CSOs constitute one important channel to reach communities. This chapter focuses on approaches to provide funds directly to communities, particularly communities that are not served by NGOs, FBOs or CBOs.

### 2. Why are communities important?

Communities play a central role in HIV/AIDS programs for many reasons:

- **“AIDS competent” communities are central to national AIDS programs.** The overall aim of these programs is to develop HIV/AIDS-competent communities, which are able to assess the reality of the AIDS problem, analyze the specific factors that place them at risk and develop strategies to address these factors;
- **Empowering and mobilizing communities.** Empowerment theory emphasizes the importance of empowering and mobilizing communities with the responsibility and the resources to protect themselves from HIV/AIDS;
- **Changing community norms and values.** Evidence from Uganda and Zambia underscores the importance of changing community norms and values in order to protect communities from HIV/AIDS. This requires large scale community participation and leadership, of both organized and non-organized communities;
- **Communities provide key AIDS services.** Communities are already delivering many key HIV/AIDS services. For example, most individuals with AIDS receive care not from formal health services or even formal community-based home care programs, but from their immediate surroundings, primarily families and communities. Most orphans receive care not from the public sector or NGOs but from informal community initiatives. Formal responses seldom reach or provide appropriate support to community initiatives and communities are seldom able to access formal support. As a result, it is vital to establish direct access, so that communities can obtain support;
- **Communities are central to large-scale responses.** The scale of the HIV/AIDS crisis necessitates the widest possible national involvement. Only through the fullest possible community involvement can HIV/AIDS responses of sufficient intensity, scope and coverage be mounted.

### 3. What must be done to support communities?

To reach both organized and non-organized communities, the following principles have proven useful:

- **Establish multiple support channels.** Each community comprises a multiplicity of sub-communities, which can be reached in different ways. It is vital to establish as many support channels as possible. For example,



some segments of communities are organized into parent-teacher associations, which may be reached through the Ministry of Education. Other segments may be organized into CBOs, such as women's groups, youth clubs or PLWHA associations, which may be linked to NGOs. Other segments may be organized into a variety of small religious communities, which may be linked to larger faith-based organizations. Many segments of communities may not be formally organized and may need to be reached through mechanisms established specifically to reach non-registered groups. The key principle is, that multiple support channels are required to effectively mobilize and support communities.

- **Ensure mechanisms to reach non-organized communities.** Mechanisms to reach formally organized communities, such as NGOs and CBOs, are better developed than mechanisms to reach non-organized communities. National HIV/AIDS programs should include a component specifically for non-organized communities;
- **Situate support channels as close to communities as possible.** The closer support channels are to communities, the easier it will be for communities, both organized and non-organized, to access support directly without having to rely on intermediaries. Thus, community support mechanisms must be decentralized to district or even sub-district levels;
- **Publicize support channels.** Support mechanisms should be publicized widely through appropriate local channels, including local government structures, schools, churches and residents' associations. They should be publicized orally, as well as in writing, to promote access;
- **The first priority is mobilization.** At first, mobilizing communities is more important than determining specifically what should be done. For example, communities may want to focus first on community care or orphan support. It is initially more important to mobilize and support such initiatives than to impose a balance among prevention, care and treatment and mitigation. As communities become mobilized, programs may gradually encourage a more balanced AIDS response. However, the first priority is to mobilize and support community AIDS responses as they arise;
- **Simplify eligibility procedures.** To enable communities to directly access funds without intermediaries, eligibility procedures must be made as simple as possible. For example, the following eligibility criteria may be proposed;
  - A community bank account where such accounts are easily opened (optional)
  - A small committee to accept and be responsible for funds
  - A simple cash book
  - A simple receipts file
- **Simplify application procedures.** Similarly, simple application procedures are required to enable communities to directly access funds. Complex application procedures merely discourage community applications. Forms and narrative requirements should be in local languages and be simple. Provision should be made for literate staff to assist communities to prepare applications or for oral applications to be reviewed and approved;
- **Assist communities to articulate needs.** Communities often lack the capacity to identify and articulate their needs. There are well developed methods to assist communities to develop the awareness to organize and respond to issues, harnessing their own knowledge and insights. For example, participatory learning and action

(PLA) or participatory rural appraisal (PRA) techniques are designed specifically to empower communities with the understanding and insights they require to develop their own responses to problems such as HIV/AIDS;

- **Encourage catalytic agents.** Even if support channels are as close to communities as possible and eligibility and application procedures have been simplified, catalytic agents can play an important role. Catalytic agents are community agencies such as local government departments, educational institutions, NGOs, FBOs or CBOs, which publicize local support mechanisms, assist communities to mobilize and to prepare and submit applications and help communities to undertake activities; the work of catalyts should be funded by national AIDS programs;
- **Promote community accountability.** Communities can provide simple financial and progress reports and random audits of community grants will be undertaken. It is vital to promote community accountability, by, for example, requiring communities to present their applications in public, publishing community grants on local bulletin boards and holding regular community meetings to update communities on progress and expenditure. Publicity and public disclosure constitute powerful and effective forms of accountability, as communities have the motivation and knowledge to ensure that funds are used as proposed and reported;
- **Develop simple performance indicators.** Performance indicators should be as simple as possible. Illustrative community indicators include but are not limited to the following:
  - Number of communities receiving MAP funding
  - Percentage of overall funding accessed directly by communities
  - Number of new communities introduced to HIV/AIDS activities
  - Number of community members mobilized through community programs

### Box 11.1: A Community Case Study From Ethiopia

In Ethiopia, community grants are being decentralized to the lowest administrative level, equivalent to a ward. Communities are informed of the existence of community funds and are encouraged to submit simple applications, in which all that is required is a broadly defined community, members who will be accountable for funds and a broad proposal for the use of funds. Applicants are required to present their applications at community forums. Applications are approved at the district level and up to US\$1,000 may be readily approved. Communities are required to submit simple financial statements and to keep basic receipts. They are required to make regular, public updates at community forums. Through this simple mechanism, two thousand communities throughout Ethiopia were mobilized and received grants in the first 18 months of program implementation.

## 4. Financial management

Although a high degree of variation among community groups precludes across the board rules and procedures, some general financial management principles and working procedures apply. Rules and guidelines do apply to community projects but the application of these rules must be correspond to the community's capacity. Policy requires communities to maintain financial management systems and procedures which are adequate to ensure that they can provide NAC/NAS or their agent with accurate and timely information regarding project resources and expenditures. Detailed information on financial management systems (FMS), and disbursement is located in Chapter 19 and Chapter 20 respectively. A summary of key guidelines follows.

- Assess the capacity of community FMS capacity and provide training where necessary.
- Determine a safe location for storing cash advances if a bank account is not available.
- Install a simple record keeping system based on cash in and cash out, in the local language.
- Establish the type and regularity of financial reports and statements and provide examples.
- Ensure that communities understand who their contacts are and the reporting structure at community level.
- Communities should be subject to random internal and external audit.
- Disbursement procedures from the community account should be well established and understood. In areas outside of the banking system, disbursements can be made through a variety of institutions that already function but are not normally used by donors, including churches, relief organizations and formal and informal commercial organizations.
- A methodology should be put in place to measure and record community contributions.

## 5. Procurement Management

Generally, very simple procurement procedures are recommended for communities under the MAP approach. This essentially includes (a) local shopping, (b) local bidding procedures. These procedures are explained in Chapter 15. Following are the minimal procurement management requirements:

- A community committee that would collect quotations and/or invite bids for goods, minor civil-works and services, evaluate them and award a contract;
- They will adopt a clear and transparent process to acquire quotations/bids, opening of bids and the award of contracts to local suppliers/contractors;
- All community groups will maintain records and receipts of all items/services procured and submit to NAC/NAS (or its authorized entity) when requested.

## 6. Lessons learned

- **Not enough funds have reached communities directly.** Experience has shown that a remarkable low proportion of HIV/AIDS resources have directly reached communities in the first year of implementation.
- **Exceptional mechanisms are required to reach communities directly.** These mechanisms include the greatest possible decentralization, extensive local publicity for community grants, vastly simplified eligibility, application and reporting procedures and an acceptance of existing community accountability and disbursement mechanisms as an effective safeguard.
- **Value of catalytic agents. Facilitating agents add significant value and should be consciously promoted.** For example, NACs may encourage local authorities, NGOs, FBOs and CBOs to apply for funds specifically to catalyze communities, with the understanding that grant performance will be assessed by the extent to which they have successfully promoted and supported community applications.



See Annex 11 (CD-ROM) for further references



# Chapter 12

## Private Sector

### 1. Why should the private sector be involved?

In addition to the enormous impact of HIV/AIDS on the private sector in human, financial and social costs, companies and professional business associations represent powerful stakeholders and effective partners in the war against the epidemic. Many private companies are already implementing HIV/AIDS prevention, care and treatment and mitigation programs that can easily be scaled up.

- **Coverage and Influence.** A large proportion of Africans spend much of their lives working in private companies which are in unique positions to influence behavior both within their own work forces (and their families) and with the broader constituencies with which they deal. Employees of certain industries, such as mining and transportation, have high levels of vulnerability to HIV and therefore carry a significant burden;
- **Results Approach.** The “bottom line” discipline and the results-oriented approach with its emphasis on efficiency and effectiveness are important to HIV/AIDS programs. Many effective HIV/AIDS programs were initiated by and piloted in the private sector, both in Africa and around the world;
- **Special Expertise.** The private sector has various core competencies which can be of particular use in the war against the epidemic. These include: financial and accounting skills, technical know-how, understanding of communications media, and the marketing and selling of products and services. It also possesses particularly valuable knowledge to reach and change opinions/behavior of large numbers of people;
- **Financial Resources.** Many private companies may be prepared to shoulder a much higher percentage of the costs of HIV/AIDS programs than the public sector or other segments of civil society, thus leveraging donor funds.

### 2. The role of the private sector today

The private sector has started HIV/AIDS programs itself both in industries whose workers are severely impacted by or transmitters of HIV/AIDS and more generally. However, the ability of small and medium-sized companies to provide sufficient financial and technical resources has been far less than for large companies and for local branches of international companies. The private sector has also participated in NACs and has begun to mobilize, often through professional associations, resources for various HIV/AIDS activities. The private sector participation in fighting the epidemic should fall under overall national HIV/AIDS strategies, and companies that seek resources from donors should fulfill established eligibility criteria. These criteria can be different depending on the size of the company, as well as taking into account the local business environment. NAC resources should supplement funds already mobilized within the private sector.

However, experience to date has shown that donor funds have not often been used to support private companies even though donor funds do provide for funding of civil society organizations, including individual private companies and various kinds of private sector associations<sup>14</sup>. In addition, a number of international private sector partnerships are available<sup>15</sup>.

### 3. Lessons learned

- **The private sector is not a monolith but very diverse.** Many different types of organizations can be defined within the private sector. The private sector can encompass commercial sex workers, independent truckers, guest-workers, micro-enterprise, the non-formal sector, SMEs, pharmaceutical and private health services, professional associations, and large national and multi-national companies. Programs that are defined and put in place to target the private sector, should recognize the different needs and types of interventions necessary to make an impact.
- **SMEs and the informal sector need special attention.** SMEs and the informal sector make up the largest proportion of the private sector in developing countries and emerging markets. They are also the fastest growing part of the private sector worldwide. They are, however, less easy to reach in a coordinated and efficient way. Options can include exploring strategies to engage them through industry associations and informal groups, often at the community level. Additionally, larger companies can be encouraged to reach out to their suppliers and supply chains and develop programs and provide technical assistance to service providers which can be funded by a National AIDS Commission (NAC).
- **Don't forget the parastatels.** Parastatels occupy an unusual position. They are often large employers, and can be semi-private. If these organizations don't fall within the public sector portion of a MAP program, they can be captured within the private sector as many of their issues are similar.
- **NAC does not reach out – the private sector does not reach in.** Despite representation on NACs, the private sector is not getting the message that resources are available to support their programs. As a consequence, the opportunities to reach large numbers of affected and infected people and to share experiences and lessons learned are more limited than they could be. Similarly, the private sector has not yet actively pursued a systematic engagement with the NAC in most countries, often because they find the “transaction costs” of dealing with bureaucratic NACs to be too high. In many countries, the private sector is actively participating in National Business Coalitions against HIV/AIDS, as a strategy to coordinate their interests and have influence on national policies and HIV/AIDS agendas. Though significant gains have been made, the private sector would like to be asked to participate and this can be done through financial support for the emerging coalitions, and a targeted communications campaign.
- **Donors, or recipients, or both?** Some private sector companies are able both to undertake HIV/AIDS programs with their own resources and to contribute technically and financially to others. However, most private companies, especially the medium and small companies that employ the largest number of workers overall, are not in this position and should receive NAC funds, with the appropriate amount of counterpart financing. Only in this way will the private sector be fully engaged in the war against HIV/AIDS and make the important contribution of which it is capable.
- **Private Healthcare is often left out.** Private healthcare is a critical partner in the ability of some countries to deliver general health services as well as scale up access to and implementation of treatment. Yet, they are often left out of the national HIV/AIDS strategy, the strategy of most Ministries of Health, and the core constituencies of the many budding Business Coalitions. Private healthcare often provides between 12% – 70% of services in many countries and is a valuable partner in national HIV/AIDS programs.

<sup>14</sup> *The private sector has been involved so far in MAP projects largely as providers of goods and services funded by MAP for implementation agencies or as contractors when various functions such as financial management and disbursement, procurement, and monitoring and evaluation have been contracted out by NACs and implementing agencies.*

<sup>15</sup> *“The Business Response to HIV/AIDS (www.unaids.org);” Global Business Council on HIV/AIDS (www.GBCAids.com); World Economic Forum (www.weforum.org).*

- **Efficient communication.** Responding in “real-time” on issues of interest to the private sector, such as information requests and financing decisions, is essential since the private sector works on a faster turn-around cycle than donors/public sector;
- **Start with large, well financed firms for piloting interventions.** Success with a highly visible private sector firm’s efforts provides a demonstration effect and paves the way for other and smaller firms to follow;
- **Promote twinning** of larger firms with SMEs in sharing knowledge about effective HIV/AIDS interventions.

#### 4. Recommendations

- **Make sure policy is well publicized.** The private sector needs to know that they are explicitly included in access to NAC resources.
- **Private sector representation in the leadership of the NAC.** To insure that NAC policies and practices are considered in the development of the overall national strategy, it is useful to have a representative from the private sector as a member of the NAC, or in a high-level position within the national AIDS secretariat.. Inviting a Chairman or Executive Director of an influential or large national or international company would provide useful perspective and involvement of the private sector in high level decision making.
- **Market MAP to the private sector.** NASs need to market the MAP approach as aggressively to the private sector as it does to other elements of civil society, through a variety of mechanisms such as: (i) establishing a private sector focal point<sup>16</sup> in NASs ; (ii) contracting out MAP marketing and project preparation for small and medium sized businesses to business associations; and (iii) building formal partnership links to national and international private sector organizations;
- **Private sector criteria.** Countries should define precise financial terms for the private sector to access NAC resources in each country, and the private sector should be encouraged to increase its participation as “donors”.
  - **Financing.** If the NAC asks the private sector to work together to mitigate the impact of the disease, either as a partner or donor, than companies will likely need more incentive than just getting free advice. Companies and organizations will expect that they can receive financial assistance to scale up programs, pilot new initiatives, and reach out to their memberships to deliver programs. In exchange, companies should offer counterpart financing and in-kind contributions, including: a network of contacts, channels of communications to business partners; material assets, such as premises, providing venues for meetings, VCT, sponsorship campaigns, equipment, goods, drugs, transport; and skills- such as management, monitoring and measurement capacities - information technology, and human resources;
  - **Transparent and simple eligibility criteria, application and selection process.** It would be useful to work with the private sector to develop criteria and an application process to access donor funds from the NAC. These criteria should distinguish between different categories and sizes of private sector companies (e.g. micro-enterprises, SMEs, large nationals, multi-nationals), as a one-size approach will not fit all. Developing a simple how-to guide for the private sector on how to access funding from the NAC is always useful.

<sup>16</sup> *The full benefits of working with the private sector will be recognized if a NAC is able to hire a private sector focal point. Because the private sector is so diverse, taking full advantage of the energy, opportunities and resources of the private sector takes specialized knowledge. This may include, (i) a full-time person within the NAS (recruited from the private sector or with knowledge of the sector to understand the essential issues), or (ii) out-sourcing the focal point function to a private sector partner as seen in Annex 12 (CD\_ROM) (e.g. Business Council, Chamber of Commerce) so that mainstreaming/outreach is delivered by a “peer”;*

- **Consider earmarking a percentage of funding for private sector programs.** It may be useful to demonstrate the intent of the NAS to ensure collaborating with the private sector will result in real benefits for both. In order to do this, a percentage of the annual funds available from the NAS might be negotiated and earmarked on an annual basis to support private sector participation in the fight against HIV/AIDS.
- **Use an industry association** – An existing association, such as a national HIV/AIDS private sector business council, labor unions, employee federations, and coalitions of associations are logical groups to work with the NAC on private sector participation. Such groups tend to include all the types of members and representative organizations that NAS would want to reach in order to provide materials, information and advice. It also has the added value of being able to coordinate resource mobilization for its membership.
- **Develop and implement a communications strategy aimed at the private sector.** NAC should develop an effective outreach strategy that will use the power of media partners to get the message out to companies about their civic responsibility to participate in the war on HIV/AIDS. It will also let companies know that resources are available to start-up programs and to scale-up successful pilots as well as point out the importance of private sector linkages with NGOs to enhance IEC. The campaign should also include specific information about how to access technical and human resources that can provide guidance for companies interested in getting started.
- **Full grants to the private sector.** If a private company wants to provide HIV-AIDS services outside its normal business operations, it should be treated as any civil society NGO and receive full grant financing.





# Chapter 13

## Public Sector (other than Health)

### 1. Why are other public sector agencies important?

HIV/AIDS is much broader than a public health problem. It touches virtually every sector of the economy. Providing effective prevention, care and treatment, and mitigation requires the involvement of many parts of the public service, and these efforts need to be expanded and coordinated. Moreover, every sector will be affected by AIDS, among both its staff and clients, and needs to plan carefully to mitigate this impact. For example, in some countries the number of teachers dying of HIV/AIDS annually is greater than the number of teachers being trained, threatening the entire education sector. In agriculture, the productivity of workers is badly affected by the epidemic, leading to decreases in agricultural output<sup>17</sup> and to food shortages.

### 2. What are the principal responsibilities of public sector agencies other than health?

Public service agencies other than the Ministry of Health are important instruments for delivering essential information and services on HIV/AIDS. The MOH is primarily responsible for clinical services - testing, diagnosis, and treatment - and for surveillance, as well as for other public health management priorities such as blood safety and medical supplies. But other ministries have primary responsibility for a wide range of preventive and mitigation activities. The major ministries typically include Education (for students, teachers and PTAs), Defense (for the military), Transport (truck drivers), Agriculture (with its wide range of contacts at the farm level), Youth, Labor and Social Affairs, Gender, Information, Construction and Housing, and others.

Ministries are also major employers. In many developing countries, the public sector accounts for the majority of formal sector jobs. Therefore, public sector employees represent a major audience for HIV/AIDS information and services.

Consequently, the MAP program supports three principal activities in sector ministries: (i) provision to ministry staff and their families of HIV/AIDS and STI education, training, research, counseling, condoms, referral to treatment and care and other support; (ii) enhancement of the ministries' capacity to provide clients and audiences the means to provide effective prevention and ways to access health care facilities and care; and (iii) sector planning to prepare for, and mitigate, the impact of HIV/AIDS on the sector. Line ministries should also prepare for future losses and staff replacements.

Funds to enhance capacity and implement programs are usually provided on the basis of annual work plans and budgets submitted to the National AIDS Council/Secretariat (NAS).

### How Line Ministries have approached the challenge?

Generally, under the MAP support, line ministries have constituted inter-ministry HIV/AIDS teams with a designated focal point. The team prepares the annual activities plan, estimates the budget requirements and submits a request for approval to the NAC/NAS.

<sup>17</sup> Data from Zimbabwe show that for families with an AIDS death agricultural output for key crops declines substantially: maize by 61%, cotton 47%, vegetables 49%, groundnuts 39% and cattle 29%.



Ministerial plans are typically phased. In the first phase, plans generally target building internal staff awareness, knowledge and capacity to provide support to staff and their families by establishing a HIV/AIDS focal point office, constituting a HIV/AIDS team, sensitizing internal staff, and expanding sensitization to the dependents of the staff. At the same time ministries tackle the policy level issues within the ministry by undertaking national HIV/AIDS policy implementation initiatives.

In the second phase a ministry expands its activities to target its external clients. This generally includes sensitization and prevention, especially IEC.

Mobilized internal and external targets of a ministry then benefit from the local response component of the MAP by submitting sub-grant proposals and taking charge of HIV/AIDS prevention, care, support and mitigation activities.

### 3. Lessons learned and recommendations

- **Line ministries are essential partners for mainstreaming HIV/AIDS, but are not yet fully involved.** Three reasons account for this. First, many ministries continue to see HIV/AIDS as the Ministry of Health's mandate and its "problem" to solve. This stems from a lack of understanding of the relationship between HIV/AIDS and other sectors. Each sector needs to appreciate the two-way relationship between HIV/AIDS and its sectoral activities. HIV/AIDS affects each sector, and each sector can help address HIV/AIDS. AIDS is progressively undermining the investments and programs in a wide variety of sectors, making it difficult to achieve goals in, for example, education or rural development. Conversely, each sector has a unique role to play in helping address the epidemic (e.g. by incorporating appropriate HIV/AIDS messages, including those against stigmatization, into the school curriculum). The second reason is that even for those ministries that have understood the importance of HIV/AIDS, adequate resources have not been available until now. And finally, line ministries are often not involved because they lack the capacity to mainstream HIV/AIDS in their areas of influence.
- **Scaling up in line ministries is taking longer than expected, in part because of institutional weaknesses within sector ministries.** Sector ministries were to create "focal points" for HIV/AIDS and submit action plans to the NAS for scaling up their activities. To date, many line ministries have been slow to assume these responsibilities and are uncertain how to proceed. "Focal points" within ministries have been too few and too powerless. The focal point role is often assigned to individuals who already have other full-time responsibilities. They lack the authority to push through action programs for their own line departments or to initiate a capacity building effort to enhance services to sector clients. Priority attention is needed to establish and fund dedicated units, not just focal points, in line ministries with full-time staff, the capacity to develop annual plans and the authority to implement them, particularly for the most critical group-at-risk - young people. Line ministries should draw on other countries' experiences, give authority to their "focal points" (high-profile, full-time professionals, vested with proper resources, including staff and identified budget lines), and enlighten their "gatekeepers" (e.g. Permanent Secretaries). NASs should not hesitate to fund establishing HIV-AIDS capacity in ministries.
- **Political will is necessary to mobilize sector ministries.** Ministries listen to political leaders. If the President, Prime Minister, or Parliament show that they expect action on HIV/AIDS and engage in regular follow-up, ministries are likely to take the epidemic seriously. In one country, the President asks in cabinet for an update on ministerial HIV-AIDS programs regularly. Another country requires each sector ministry to include a line item for HIV/AIDS in its annual budget request, or the request is returned.
- **The Ministry of Education is pivotal in the fight against HIV/AIDS, but often among the most difficult to mobilize.** Ministries of Education are the largest employers in most countries and reach every community. They interact daily with the most important single audience for the HIV/AIDS message—youth. But because of their size and the inherent difficulty in reaching consensus or changes in curricula, they have often been slow in responding to the challenge effectively. The first priority for a multi-sectoral program should be to build full-time capacity in the

MOE to mobilize its tremendous potential for influencing attitudes, values and behaviors toward the disease. MOE needs to intensify information for all (including establishing resource centers in schools), introduce and/or intensify HIV/AIDS at the tertiary level, and build bridges between MOE and other ministries dealing with children. HIV/AIDS should be a subject matter in the curriculum.

- **Getting started:** begin with an assessment of the impact in every sector, “sensitization” of and advocacy to senior managers for ownership, reduction of stigmatization, and drafting of an initial program. Beginning a new program within an organization is always a challenge. It is not part of the bureaucratic routine. In HIV/AIDS, there is often little understanding of the need for a dedicated effort. Experience suggests that a good sequence for getting started within line ministries is to (i) undertake a situation analysis of the impact of HIV/AIDS (a) in the core ministry itself and the level of awareness among staff; and (b) among the clients of the ministry<sup>18</sup> (ii) use the information generated to make senior officers aware of the magnitude of the problem within their own organization; (iii) begin preparing a strategy and initial work program for review with the NAS; and (iv) build bridges between countries. To ensure ownership, it is best if this process is led or overseen by staff from the sector ministry itself; with the assistance of consultants in whom the sector ministry has trust. Rarely can sector staff conduct the whole assessment/program preparation effort themselves; specialized, local consultants are almost always needed.
- **The partnership with the NAS has to be stronger.** Even where focal points do exist, the relationship with the NAC Secretariat and other ministries has not been sufficiently effective. Most ministries have submitted some work plan to the NAS for review. Typically, the plans lack innovation and knowledge of good practices and largely appear to be based on a single template. They also tend to be very ambitious relative to capacity. This suggests that many line ministries still do not appreciate the importance of their roles in the fight against HIV/AIDS. The quality of work plans varies widely, often creating tensions between the ministry and NAS. The provision of technical support to these HIV/AIDS units from the NAS, technical support groups or perhaps secondments from other units would assist in the development of more appropriate and harmonized annual work programs. At the other extreme, ministries may have done considerable work on HIV/AIDS before the MAP that the NAS has not always recognized. Line ministries and the NAS must work more effectively together, and see their relationship as mutually beneficial not adversarial. NAS should compile data bases of good practices of HIV/AIDS activities and hold annual joint review meetings with line ministries.
- **Contracting additional support is an option.** Many line ministries are already overwhelmed by their current responsibilities and lack the capacity to assume new functions. Even with strengthening by the MAP program, ministries may find that subcontracting the delivery of services to staff and clients and audiences will be more effective than adding to their existing duties. The line ministry would retain responsibility for planning and oversight, but would contract implementation to the private sector, NGOs or other public agencies with demonstrated capacity.

<sup>18</sup> *The assessment of the impact of the HIV/AIDS among a ministry's clients is of critical importance and can often benefit from studies already available in the HIV/AIDS literature. The mining and transportation sectors have been particularly active in addressing the impact of HIV/AIDS in their sectors.*

**Box 13.1: Cross-fertilizing: Public Sector Subcontracts NGO**

The Ethiopian Roads Authority (ERA) is a public sector institution with a staff of 15,000 and an additional 5,000 sub-contractors across the country. Road workers are often separated from their families for several months and are therefore particularly vulnerable to HIV. In addition, appropriately designed prevention programs targeted to ERA workers can have a spill-over effect on contact populations.

In January 2001, ERA submitted a proposal to the National HIV/AIDS Prevention and Control Secretariat (NAC Sec) for the development and implementation of an awareness and prevention strategy for their workers and sub-contractors. This strategy included three major components: Information Education and Communication (IEC), free provision of condoms, and access to voluntary counseling and testing services.

Given ERA's relative lack of capacity and technical expertise in HIV prevention, its senior management decided to develop the proposal jointly with a large local NGO and requested funds to sub-contract implementation of the proposal to the NGO. The proposal, for which ERA will maintain general oversight, has been approved.

- **Lack of funds for scaling up sector response.** Many line ministries benefiting from the MAP have successfully implemented their annual plans. However, “insufficiency of funds” to scale-up their sector-wide efforts is a growing challenge even though additional MAP funds are available. National AIDS Secretariats sometimes feel compelled to “ration” funding even though additional grant funding is available, as needed.. For example, the education sector needs far more funds to address HIV/AIDS issues in the curriculum, teacher training, classroom materials etc., than the token financing that is commonly provided from the NAC/NAS.
- **Although all ministries should be given equal opportunity to start HIV-AIDS activities, let a few ministries take the lead in the first year.** Not all ministries will be equally well prepared. During project preparation and the first year of implementation, it is a good idea to let a few “champion” ministries which have already developed good HIV/AIDS plans take the lead in implementation. They can provide a model for others to follow and help test mechanisms that can later be refined and applied to other ministries. During this initial phase, ministries that are not as prepared should receive support to develop good plans of their own.



See Annex 13 (CD-ROM) for further references



# Chapter 14

## Health Sector Response

### 1. Introduction

The health sector response involves a broad range of partners including the Ministry of Health, civil society organizations and the private sector. With respect to national HIV/AIDS policy and programs, like other key sectors such as education, defense, or transportation, the health sector will collaborate with the National AIDS Council in fulfilling the NAC function of overall program oversight, coordination and facilitation. NAC coordinates HIV/AIDS activities for all sectors in the context of the multi-sectoral HIV/AIDS response. The Ministry of Health (MOH) can work with the NAC to coordinate government and non-government partners in the health sector as well as itself implementing many essential HIV/AIDS programs.

The health sector has specialized technical expertise and mandated responsibilities in the area of HIV/AIDS and related diseases. The MOH, in its role of technical leadership in the health sector, has the normative responsibility for health sector policy development, epidemiological surveillance, setting standards and regulations pertaining to voluntary testing, case management protocols, the blood supply system and its quality assurance, and provision of ART and drugs for STI, TB, and other opportunistic infections.

The health sector also has a dual role as the main supplier of health services to its external clients and as provider of services focused internally towards its own employees. It is important that the health sector not neglect the needs of its internal clients with regards to HIV prevention, care and treatment activities.

Within the context of the national HIV/AIDS program, at least four broad areas specifically relate to the health sector : First, health sector personnel will require additional training in how to provide HIV/AIDS services<sup>19</sup>, counseling related to these services and/or products, as well as preventive measures when interacting with patients. Second, health facilities can serve as referral units to support HIV/AIDS activities carried out by other ministries, non-governmental organizations, the private sector, and communities, but on an expanded basis. In this regard, it may be in the interest of the health sector providers to reach out and strengthen the capacity of other sectoral agencies to provide certain basic services. Third, health sector personnel at all levels are key allies in the fight against HIV/AIDS, in its prevention, treatment and care dimensions. Fourth, as HIV-AIDS program expand, especially for treatment, the number of trained health sector staff will have to expand dramatically.

The shift from a narrow focus on the health sector to a multi-sectoral approach, and the consequent placing of the HIV/AIDS Council/Secretariat outside the health sector has sometimes resulted in confusion and concern among some health officials. To deal with such concerns certain national HIV/AIDS programs have decided to give health ministries great visibility and funded separate health sector components.

### 2. Why is health sector response important?

The unique technical capacity and services the health sector can provide in the achievement of national HIV/AIDS program objectives should not be overlooked. The team preparing a national HIV/AIDS framework should give special attention to health sector needs in the fight against HIV/AIDS. The following are the major reasons to involve the health sector in the national program:

<sup>19</sup> Kenya-MAP (MOH – AIDS Coordination Unit) looked at training gaps for 40,000 employees and has identified the training needs for public health officers, midwives, nutritionists, clinical staff, etc. 4000 MOH staff were trained in a pilot program.

- The historical role of the health sector in the fight against HIV/AIDS, and the existing capacity which can be mobilized;
- The MOH, as a specialized agency of the sector, plays a unique role in providing technical services essential to combat HIV/AIDS, such as clinical diagnosis and treatment of STIs, TB, other OIs and ART;
- The MOH is the primary agency responsible for epidemiological surveillance;
- The sector has the widest geographical network of health facilities/infrastructure (both public and private), in most countries;
- The sector employs a large number of health care personnel, and provides avenues for practical training; and
- It is an important participant in behavior change communication;
- The role of the health sector will grow rapidly and broadly as lower prices for and more funding of ARVs make scaling up of treatment more financially feasible.

### 3. What are the roles and responsibilities of the health sector?

A strong health system is an important component for success in the fight against HIV/AIDS. Within the public sector, the health system bears primary responsibility for care and treatment, and plays a pivotal role in many preventive activities. The Ministry of Health, and more broadly the health community which includes institutions of higher learning, private health practitioners (including traditional/indigenous health practitioners), have specialized roles in the prevention and management of HIV/AIDS, STI, and other opportunistic infections. TB specifically deserves special attention and emphasis because it represents an area which the health sector can contribute to the effectiveness of HIV/AIDS control program, and one which has been vastly under-utilized in most countries.

The health sector can play a very prominent role in the national response through making provisions for HIV prevention, treatment and care. The health sector, whether public or private, can provide technical guidelines for care and support, provide clinical care, and conduct epidemiological surveillance (See Chapters 21-23 regarding specific program themes and the role of the health sector). In addition, the health sector has a responsibility towards its own employees some of whom may not be medically trained and thus need targeted interventions with regards to HIV prevention, care and support. The specific deliverables from the health sector cover a continuum of services from prevention through care, and support, and may include the following:

- Scaling-up of the national sentinel surveillance system, epidemiological monitoring, and contributing to program evaluation;
- Coordination of condom procurement, support for a social marketing program, and a significant role in the distribution of condoms
- Services to prevent mother-to-child-transmission (MTCT) including counseling on breastfeeding, family planning, maternal support, and care for HIV positive pregnant women and children;
- HIV/AIDS care and treatment policy development, setting guidelines and standards of care ( clinical and home based), voluntary counseling and testing (VCT) protocols, as well as carrying out VCT activities, and promotion of behavior change (see **Box 14.1** for an example of a health sector NGO, founded by a private health service provider, involved in VCT service delivery in Ethiopia);
- Strengthening of the national system and other referral hospitals for dealing with HIV/AIDS, STIs, and other opportunistic infections, especially TB;
- Practical training of health workers and laboratory technicians;
- Guidance in the provision and monitoring of anti-retroviral therapy;

- Developing, approving and implementing a HIV/AIDS waste management plan including training of staff (where capacity is limited, out sourcing should be considered);
- Scaling up of activities for HIV vulnerable or “core” groups in collaboration with other partners, including nutritional support activities;
- Establishment and/or support to others of the primary level of care for people infected and affected by HIV/AIDS, including community based care programs and others in the public sector;

#### Box 14.1: The Bethzata VCT Experience in Ethiopia

Bethzata VCT project was developed by an NGO with experience in private provision of VCT services. Its proposal to provide VCT on a much wider scale was jointly funded between the EMSAP and the NGO's parent health care provider organization (Bethzata Medical Center). Within the first two months of project launching, more than 1,200 clients were counseled and tested at a single site, and client uptake continued to rise.

Several features contributed to the success of the Bethzata VCT project, including : early beneficiary assessment using social survey; wide stakeholder consultations; strong outreach efforts; streamlined processes; and strong referral network for to care, support and treatment to those counseled who test HIV positive.

### Financial management

There are two possible ways in which the MOH can receive finances to implement its activities:

- MOH does not operate any bank account and all disbursements are made from the NAC/NAS - managed project account; and
- MOH manages a separate project account and undertakes its management.

The *first* option is recommended if the MOH does not have an existing financial management capacity for a donor-financed development project. The *second* option is feasible if there is already satisfactory financial management capacity and the MOH can manage the financial resources with minimal risks. (Financial management is treated in detail in Chapters 19 and 20)

### Procurement management

If a MOH has the capacity to manage project finances, it may also manage some procurement of goods, services and works, especially the procurement of drugs and medical supplies. This situation is ideal when a MOH is already implementing a donor financed sector development project and has a fulltime procurement officer. Otherwise, it is suggested that all procurement for the MOH be managed by the NAC/NAS (or its authorized entity). Procurement aspects are treated in detail in Chapter 21.

#### 4. Lessons learned and recommendations for MAP projects

- **The Ministry of Health has often been less involved** than it should be in the early phases of the MAP initiative. MOH must be an integral part of the national response and actively involved in the national program. MOH provides health-related technical services which only it can provide, and which are relied on by others. This means that within the MOH organizational structure it must have the capability to respond to HIV/AIDS within a multi-sectoral context.
- **The shift to a multi-sectoral approach and the placing** of the HIV/AIDS Council/Secretariat outside the health sector has in certain cases resulted in concern among health officials. There should be a clear delineation of roles and functions, and regular and open dialogue between NAS and the MOH HIV/AIDS structure. NAS's function is to coordinate the national response while MOH leads the implementation of the health response, which is an important part of the national program. These coordination and implementation roles must be understood by the MOH and NAS, but also by all HIV/AIDS partners;
- **NAS staffing should be diverse without depleting the technical skills of the MOH.** MOH needs all the qualified personnel it can muster to fill its health sector responsibilities. NAS has a different set of responsibilities which require a multi-sectoral skill mix. If the MOH preserves its sector staff and NAS gains staff from other sectors, a “win-win” situation would result in which both MOH and NAS acquire and keep the respective skills they need.
- **The financial management capacity of the MOH** should be assessed and if adequate capacity exists, the Ministry should manage a separate program account;
- **The procurement of health sector goods, works and services** should be managed by a specialized health sector agency such as the MOH, subject to a satisfactory existing procurement capacity. Procurement of ARVs, and medical equipments are examples of situations where generic procurement processes may not apply;
- **Global experience indicates that while a MOH** can assist with clinical services for vulnerable groups, NGOs are sometimes better at outreach for other groups such as sex workers, orphans or vulnerable children, and there are already promising NGO efforts in many countries;
- **Faith based organizations play a particularly important role in community based care programs** for which MOH may develop standards and provide support. In general, ministries of health should be open to the provision of many health care activities by non MOH agencies, including from civil society and the private sector;
- **Condom procurement and social marketing through global mechanisms** (e.g., through UNFPA) require special attention.
- **Adequate attention should be given to logistics and supply management.** Health sector commodities have peculiarities in terms of needed complements, shelf life, standards and the quality assurance measures needed. It is important to make such considerations during the procurement planning process, and to ensure that adequate logistical system is in place for distribution of commodities.



See Annex 14 (CD-ROM) for further references



# Chapter 15

## Decentralized Public Sector Agencies

### 1. Introduction

Decentralized public sector agencies play an important role in bringing MAP resources closer to beneficiaries in general and to communities in particular. Under the MAP, important aspects of project decision-making, implementation, financial management and monitoring and evaluation are devolved to decentralized levels of government.

This chapter provides lessons learned that may assist a MAP country in identifying a suitable decentralized project management and coordination process.

### 2. Why sub-national level response?

The major objective of decentralization of project implementation responsibility under the MAP is to bring the project resources nearer to the project beneficiaries, create wider ownership, and empower government's service delivery structures to make decisions that are for the benefit of their constituencies in the fight against the HIV/AIDS.

### 3. What are the possible sub-national level government entities under the MAP?

#### Sub-national responses through NAC/NAS

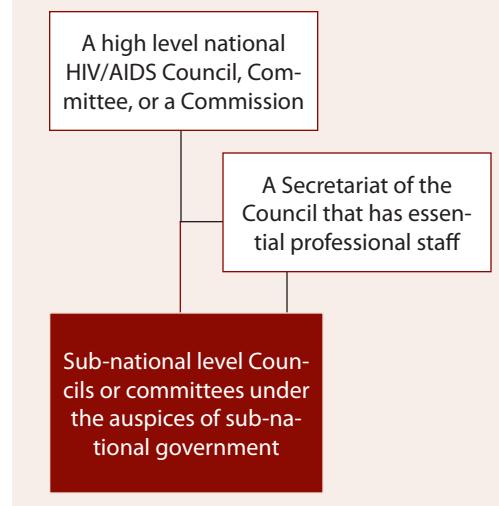
Generally, there are two tiers of management structure involved in MAP projects: (a) a high level HIV/AIDS Council, Committee, or a Commission (NAC), which is supported by a secretariat having a group of professionals; and (b) a sub-national level HIV/AIDS committee established under the auspices of an appropriate level of the government structure (Figure 15.1).

The membership of the NAC should equally represent the public and non-public sectors. The NAC establishes its secretariat (NAS), staffed with the professionals and technical personnel who essentially perform the coordination of the MAP project but not implementation.

Typically, the NAC/NAS creates HIV/AIDS committees at lower levels of government to coordinate and facilitate community level subprojects. In principal, such committees should be established at the lowest possible level with the recommended membership of 50-50% representation from the public and non-public sectors.

*Please refer to Chapter 7 on NAC and NAS for a general description of their roles and responsibilities.*

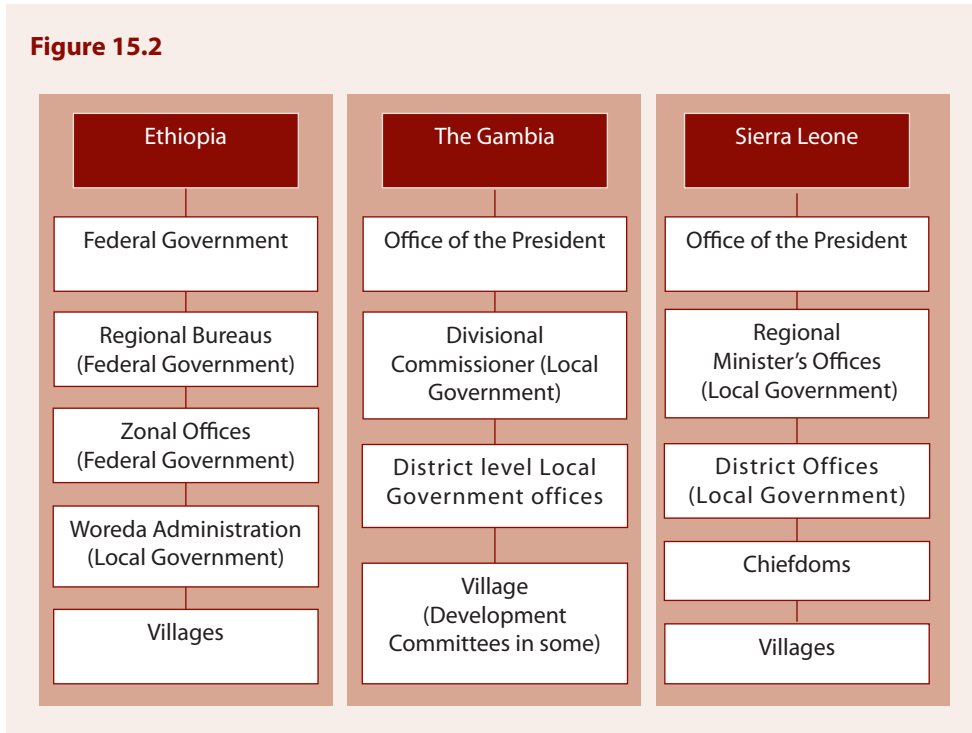
**Figure 15.1**





### Typical government hierarchies

The government structure differs from one country to another; therefore, identification of an appropriate level(s) of decentralized government body for the MAP should be made accordingly. Examples of government hierarchy in several MAP countries are presented in Figure 15.2.



### Criteria for selecting an appropriate government body for the MAP

Governments often establish HIV/AIDS Committees or Councils at the following three levels under the auspices of a relevant government body:

- A National HIV/AIDS Council and its Secretariat (NAC/NAS) – **top** level, preferably under the office of the president or vice-president. NAC (through its secretariat or directly) may constitute HIV/AIDS committees at:
- A regional, divisional, or provincial level – **middle** level. This may be suitable for geographically large or populous countries; and may be under a local government body. For example, the regional government (Ethiopia) or under the district commissioner's office (The Gambia).
- A district (or sub-district level) – **lower** level, under the local government. For example, at Woreda (District) level in Ethiopia.

Normally, the sub-national committee should be established at the lowest level where all the following stakeholders are present.

- Existence of a local government body;
- Key ministry representatives present (for example, ministries of agriculture, education, and health);
- Presence of NGOs;
- Presence of Community Based Organizations.

**How many levels of decentralization?**

The question of having sub-national HIV/AIDS committees only at the lowest level possible, or to have them at the various levels of the government structures, should be considered with care. Both options have positive and negative points.

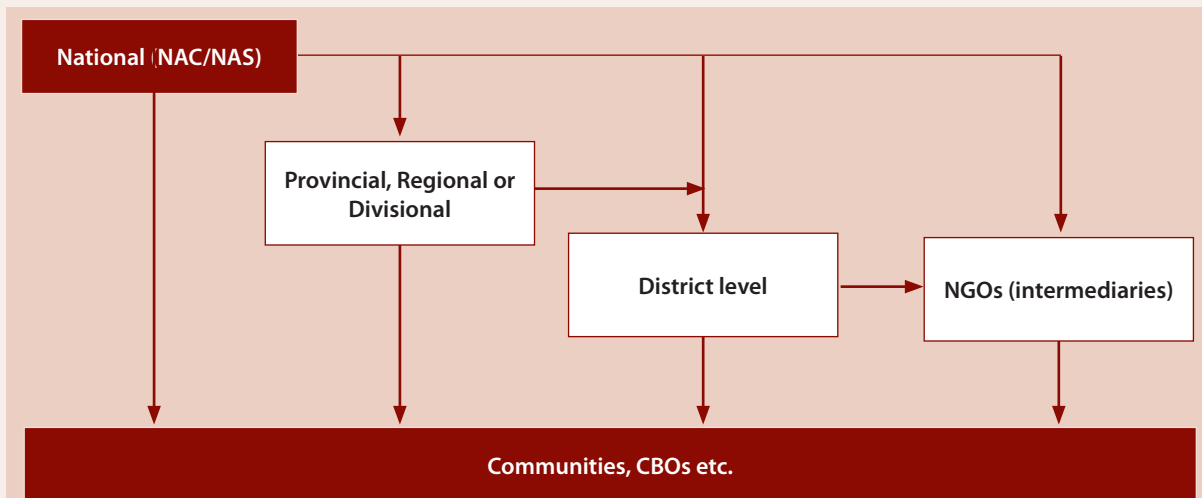
For larger countries (geographically or population), it may be advantageous to have intermediary level government bodies (provincial/regional/divisional) to be subsequently responsible for a number of lower level HIV/AIDS committees (district/woreda/constituencies; for example Ethiopia, Kenya). However, this will depend whether there is sufficient capacity in NAC/NAS to: (a) establish these committees, (b) mobilize them, and (c) provide necessary resources to them quickly – and to sustain the support. The coordination of implementation activities of many committees at multiple levels of government hierarchy has so far proven to be a major challenge.

The disadvantage of such structures is that they tend to create additional bureaucracy which takes time to be established and mobilized; and which slows down the process of getting resources nearer to the beneficiaries as fast and as efficiently as possible, which is one of the main objectives of the MAP.

The preferred option is to have sub-national level HIV/AIDS committees as close to the beneficiaries as possible, with minimal intermediary layers. However, a careful management capacity assessment should be made first. This means, if the government system includes district level committees and if there are too many districts, then the supervision and coordination task may become a serious bottleneck during project implementation. Thus, a provincial/divisional (or one level higher) HIV/AIDS committee may be more appropriate.

The major benefit of having a competent sub-national HIV/AIDS Committee under a local government body is that a large number of small-scale community based subprojects stand a chance of being quickly appraised and approved and implemented without being referred back to NAC/NAS for lengthy approval.

**Figure 15.3:** Figure 15.3 a, b, and c present 3 possible scenarios (arrows show flow of funds):



**Figure 15.3a** Grant funds can be channeled down through all possible government bodies (NGO shown as example)

Figure 15.3 b: Scenario 2

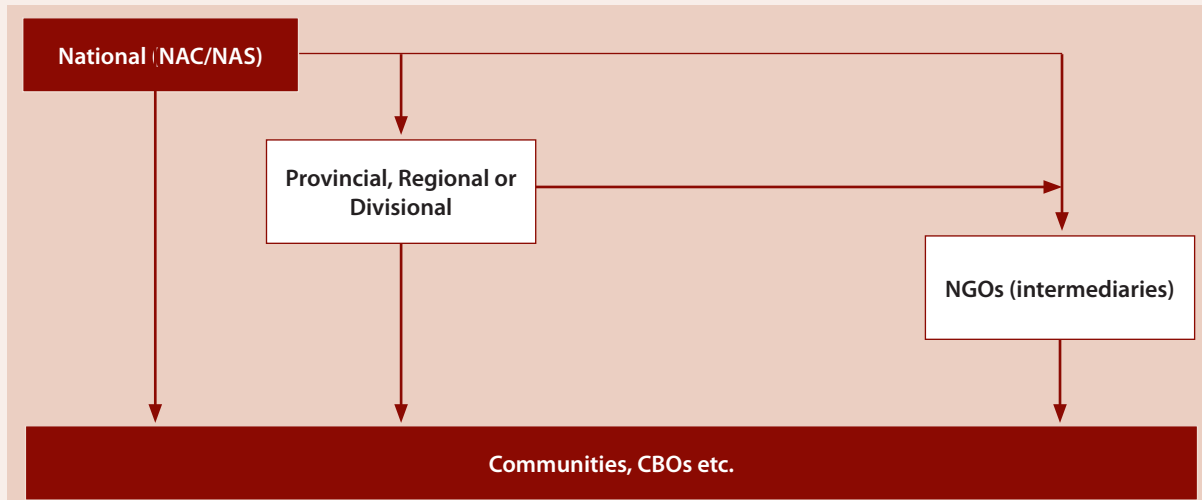


Figure 15.3b Grant funds can be channeled down through National and Provincial bodies only (NGO shown as example)

Figure 15.3 c: Scenario 3

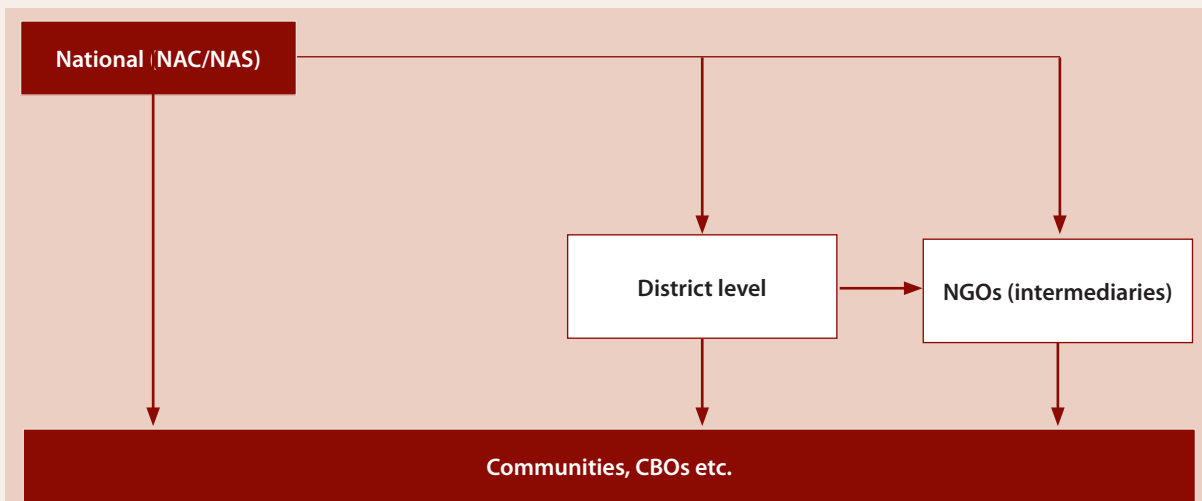


Figure 15.3c Grant funds can be channeled down through National and District bodies only (NGO shown as example). This seems to be a particularly “empowering” scenario.

There are two main cascades of decentralization of public sector funds at the sub-national levels: (a) local government, and (b) public sector functions (or line ministries such as, agriculture, education and health). MAP projects should ensure that these two cascades are operationally linked at the sub-national level. This warrants representation of at least key public sectors.

Another channel to bring MAP resources to the communities as fast as possible would be to use existing social fund mechanisms (if there is one). An operational and experienced social fund mechanism may be a faster way to deliver MAP resources to communities. NAC/NAS can sign a memorandum of understanding with the national social fund management for the purpose<sup>20</sup>. However, there are also constraints (See Chapter 11).

### Composition of decentralized HIV/AIDS committees

Members of the sub-national HIV/AIDS committees might include, for example, the divisional commissioner (as a permanent member but not necessarily as a chairperson), representatives of NGO/CBOs, representatives of participating line ministries, religious groups, women and youth, and people living with HIV/AIDS. The chairperson is recommended to be selected among the members for ideally a one-year period, on a rotational basis. The selection of members and their responsibilities should be determined on a participatory basis.

All community-based activities are usually implemented through NGO/CBO and CSOs (including the private sector). The committee would receive applications for small to medium size subprojects, appraise the proposal for approval and monitor the implementation of the subprojects.

### Sub-national responses through participating line ministries

The participating line ministries to the MAP project would essentially focus on implementing their planned activities through their existing channels. These may include:

#### (i) At the national level

- Appointment of a focal point at the central ministry level. This can either be (a) a fulltime new position under the MAP, or (b) a fulltime secondment of a relevant existing staff (financed by the government). This person would have the responsibility of coordinating and supervising all HIV/AIDS relevant initiatives in his/her ministry, and would report to the highest level (a permanent secretary or the minister);
- Constitution of an intra-ministry HIV/AIDS team. This team of a few key persons, with the assistance of the focal point, could be established in each participating line ministry. This facilitates in several ways: (a) ownership of initiatives and plans, (b) sharing of responsibilities during planning and implementation, (c) a team approach towards MAP objectives.

#### (ii) At the sub-national level

- MAP resources can be used to develop capacity at subsequent government levels within the line ministries. For example, a core team of 2-3 people at regional/divisional/provincial and district levels fully sensitized in HIV/AIDS related issues and matters; who become champions of MAP initiatives for their colleagues and their clients;
- In certain instances, for example the Ministry of Education, may also create a core team for a cluster of schools from a group of teachers to become focal points for that cluster;
- These sub-national level core-teams may be provided with essential resources as deemed necessary to implement MAP initiatives;
- The representatives of line ministries should be the members of Sub-National HIV/AIDS Committees to integrate their efforts and coordinate their activities at the sub-national levels.

<sup>20</sup> In one country a social fund meets initially with a community to discuss the priorities for traditional development projects for which the community can have access to "loan" funds. Only after this process is complete does the social fund discuss with the community HIV/AIDS projects which are provided as grants. This separation maintain the integrity of the traditional social fund while allowing MAP program to use this mechanism in the war against HIV/AIDS.

### Harmonization/coordination

Line ministries (or their sub-national offices) do not manage the community grant funds under the MAP. This fund is managed by the sub-national HIV/AIDS committees. However, line ministry representatives would be members of the committee and their major role would be to mobilize their colleagues and their clients to have access to the community funds and to undertake community based initiatives per their priorities and within the MAP objectives.

## 4. Financial management

All Sub-National HIV/AIDS Committees should have the capacity to:

- Manage a bank account (for example, the district accountant, or an accountant hired under the project as an individual or through a financial management firm);
- Appraise community subprojects to ensure basic financial management aspects are clear;
- Consolidate expenditure statements and preparation of periodic financial reports (also see Chapters 19 and 20 on financial management and disbursements).

The line ministries (including the Ministry of Health) do not need to have a decentralized financial management set-up. Considering their scope of activities, which is generally going to be mobilization of their staff and clients, they can manage their finances from the central level.

There are two options for the financial management of the participating line ministries: (a) financial management done by the NAC/NAS and the disbursement of finances directly from NAC/NAS; and (b) each participating line ministry operating a MAP project bank account and conducting its financial management itself.

The second option is only feasible when there is satisfactory capacity for managing project finances. The disbursements can be made based on annual work plans.

## 5. Procurement management

### *(i) Sub-national level HIV/AIDS committees*

- The sub-national level committees would follow the procurement procedures set out by the government which have been agreed with the funding agencies during project preparation. There are two types of procurement they would undertake: (a) procurement related to operational expenditures and consumables including hiring of consultant services, firms, NGOs and individuals; and (b) contract management of the community grant component. Also refer to Chapter 21 on procurement;
- The MAP resources from NAC/NAS level can be used to train sub-national committee personnel in the basics of procurement planning and management, including appraising and monitoring procurement activities carried out by subproject implementers.

### *(ii) Line ministries*

- If a line ministry at the national level has sufficient procurement management capacity, then the MAP project can let the ministries do their own procurement and be accountable to NAC/NAS. The Ministry of Health, due to its unique and technical responsibility, should ideally have its own procurement management unit. However, this should be carefully assessed during project preparation.
- To date, there has been no need to decentralize line ministries procurement responsibilities to its sub-national office.

## 6. Monitoring and Evaluation

- All national and sub-national entities should be responsible to report periodically on three aspects of project implementation: (a) physical implementation; (b) financial status; and (c) monitoring of program activities;
- The frequency, content and format of the reports should be agreed during MAP preparation and revised as suitable during implementation;
- The sub-national HIV/AIDS committees should report on the activities carried out since the last report including financial statements, and on the subprojects processed and respective amounts disbursed;
- The line ministries should report on the activities carried out since the last report and the financial statements.

## 7. Lessons learned and recommendations

- **Empowerment should be maintained.** If a central feature of MAP design is to empower implementing agencies by giving them: (a) the authority to decide on what HIV-AIDS programs they wish to undertake; and (b) the money to accomplish (a), creating sub-national structures should not result in a “command and control” mentality that disempowers implementing organizations, especially those at the community level.
- **Sub-national level HIV/AIDS committees should be established at the lowest level possible where all main stakeholders are present.** The fewer the levels of government hierarchy involved in getting resources down to the communities, the better and faster is the response. However, establishment of the number of decentralized HIV/AIDS committees should be directly relevant to the coordination capacity of the National HIV/AIDS Secretariat; There are serious coordination challenge associated with decentralized systems, especially if the country is large (geographically or in terms of population);
- **50-50% membership** of government and non-government representatives in NAC and in the sub-national HIV/AIDS committees has helped in maintaining transparency, equity in using project resources, and getting high level commitments from the government and non-government sectors equally;
- **Emphasis should be put in the capacity development** of the members of decentralized bodies in HIV/AIDS program planning and management. There should be regular refresher training programs;
- **Generally, the highest level government representative (for example a commissioner or a member parliament) at the sub-national level sometimes acts as the permanent chairperson of the HIV/AIDS committee.** Since they have many other responsibilities, they usually do not find time to regularly chair the committee meetings and approve community projects. Therefore, it is more practical that the chairperson be selected among the members through a participatory approach, and rotated on annual basis. This will ensure an operationally functional HIV/AIDS committee.
- **Local politics may influence** the proposal review process as well as the control of funds. This can be mitigated by having broad stakeholder membership and open meetings;
- **A sub-national HIV/AIDS committee integrates other line ministries at that level.** For example, a district education officer, or a district extension worker etc. participates, thus improving sub-national level multi-sectoral planning and coordination;
- **In each line ministry at all government levels the presence of a core team (2-3 persons), fully sensitized in HIV/AIDS related prevention and care issues and MAP objectives,** with access to essential relevant IEC materials and other necessary resources, including financial resources, can greatly benefit other ministerial staff, their dependents and their clients at large.

- **The duration and the process involved in processing a grant application at the sub-national level should be clear to the grant applicants.** These applicants should have the right to complain to NAC/NAS if a sub-national office does not take action within the application processing time. Criteria for the grants should be so clear that the applicants essentially “self-select” themselves.
- **Motivational means for HIV/AIDS committee members at the sub-national levels** (within the decentralized system) should be considered in the institutional arrangements and financial allocations;
- **There are cases where decentralization at all government levels has encouraged the establishment of ‘briefcase’ NGOs/CBOs with diverse motives.** However, as long as these NGOs/CBOs demonstrate basic subproject management skills, a MAP project can finance their proposals, but priority should be given initially to scaling up activities of existing/experienced NGOs/CBOs;
- **Demand for subproject funding in some countries make exceed immediately available funds.** However, some measures can be undertaken to finance prioritized activities in the submitted proposals. Specific instructions/guidelines should be distributed to the decentralized bodies in coping with such situations. Since it is likely that additional funds can be made available from donors, including through the MAP program, “rationing” of funds in the medium term would not appear necessary;
- **An integrated communications strategy should be prepared and implemented** among the decentralized agencies at all levels (national, regional/provincial, district and village);
- **Fiduciary (financial and procurement) reporting system** should be developed and implemented before the financing of the sub proposals. Many MAP countries are currently facing reporting problems;





# Chapter 16

## Local Government Responses to HIV/AIDS<sup>21</sup>

### Introduction

There are three elements to sub-national responses: (i) local government responses<sup>22</sup> (mainstreaming, workplace policy, etc.), (ii) decentralized coordination and support of civil society, private sector and public sector activities at a local level (funding community sub-projects, and ensuring continuum of care at local level) and (iii) deconcentrated public sector functions (ministry of education, agriculture, etc.)<sup>23</sup>. The way in which a National AIDS Program structures, supports and manages these responses will depend on a range of factors, but will likely be closely linked to the extent and capacity of decentralization in the country.

Local authorities, representing the level of government closest to communities, have an important role to play in a decentralized HIV/AIDS response both with regard to local government staff and their families and to the numerous clients of local government. In most countries, towns and cities have the highest prevalence (due to high concentrations of vulnerable groups, transport hubs, etc.) and transport routes from towns and cities are central to the spread of HIV/AIDS to rural areas. In addition, local authorities are faced with an increasing demand on services (health services, land, care for orphans, etc.) and a decreasing capacity for populations to pay for services. The local investment climate suffers as does the local government workplace, as human and financial resources are diminished.

The major benefit of having a competent sub-national HIV/AIDS Committee under or linked to a local government body is that a large number of small-scale community based subprojects stand a chance of being quickly appraised and approved and implemented without being referred back to NAC/NAS for lengthy approval. Local authorities are also well-positioned to facilitate real coordination at the local level- with civil society organizations as well as decentralized line ministries – to ensure coverage and a continuum of prevention and care for those infected/affected. By utilizing existing local government institutions and over time integrating HIV/AIDS into Local Development Plans, the sub-national responses to HIV/AIDS can be institutionalized and efforts to promote effective local governance can be enhanced.

### 2. What is gained from decentralizing the implementation of National AIDS Program?

A successful sub-national response will effectively coordinate and support (with NAC funds) local actors (civil society, public sector, private sector, and local authorities) in providing a full range of HIV/AIDS prevention, treatment, care and mitigation activities.

<sup>21</sup> This issues discussed in this chapter have been adapted from *Local Government Responses to HIV/AIDS: A Handbook* which provides more detail and practical examples and tools for Local Government Responses to HIV/AIDS. See [www.worldbank.org/urban/hiv/aids](http://www.worldbank.org/urban/hiv/aids). Also available in French and Portuguese.

<sup>22</sup> The lowest level of government where key sectors and elected representatives are represented. In many countries local governments are responsible for identifying and implementing local development planning.

<sup>23</sup> This topic will be dealt with in greater detail on Chapter 13 on Public Sector Response.



Table 16.1

Supporting Community Responses (by NGOs, CSOs, FBOs, Private Sector, etc.)	Coordinating Local Activities (by LG and/or DAC)	LA Own-activities (by LG)
<ul style="list-style-type: none"> <li>• VCT</li> <li>• Prevention and advocacy</li> <li>• Home-based care</li> <li>• Legal support</li> <li>• Support to vulnerable groups (commercial sex-workers, truckers, youth)</li> <li>• Care for orphans and vulnerable households</li> <li>• Peer group support for PLWHA</li> <li>• Treatment for OI, ARVs</li> <li>• Income-generating activities</li> </ul>	<ul style="list-style-type: none"> <li>• Identifying all AIDS service providers in local areas and ensure that there are adequate linkages and referrals between them</li> <li>• Conducting situation analysis to determine local priorities</li> <li>• Identifying gaps or overlaps in services</li> <li>• Developing a district HIV/AIDS plan that is coordinated with all decentralized line-ministries, and local government development plans.</li> <li>• Providing clear and transparent mechanisms for reporting of all activities</li> <li>• Improving the environment and opportunities for income-generating activities</li> </ul>	<ul style="list-style-type: none"> <li>• Workplace policy for local government (including non-discrimination policy)</li> <li>• Peer education and prevention for municipal staff</li> <li>• Referral linkages to care and treatment for staff</li> <li>• Mainstreaming of HIV/AIDS activities into all departments (education, health, land, roads, etc.)</li> </ul>

### 3. How many levels to a sub-national response?

Government often establish HIV/AIDS Committees or Councils at the following three levels under the auspices of a relevant government body:

- A National HIV/AIDS Council and its Secretariat (NAC/NAS) – top level, preferably under the office of the president or vice-president. NAC (through its secretariat or directly) may constitute HIV/AIDS committees at:
- A regional, divisional, or provincial level – middle level. This may be suitable for geographically large or populous countries; and may be under a subnational government body. For example, the regional government (Ethiopia) or provincial governor (Mozambique).
- A district (or sub-district level) – lower level, under the local government. For example, at Woreda (District level in Ethiopia).

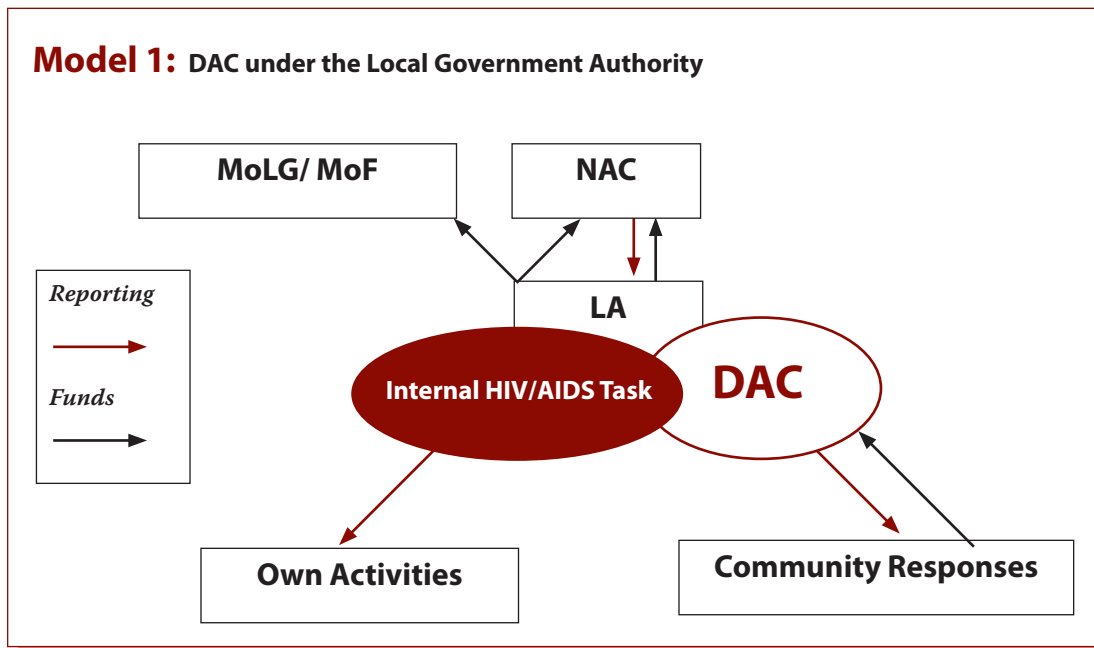
Normally, the sub-national committee should be established at the lowest level where all the following stakeholders are present.

- Existence of a local government body;
- Key ministry representatives present (for example, ministries of agriculture, education, and health);
- Presence of NGOs;
- Presence of Community Based Organizations.
- Lowest government level of formal planning and budgeting (e.g. District Development Plans)

#### 4. How to structure the most local level of response: the District AIDS Committee<sup>24</sup> (DAC)?

In most cases, the establishment of a District-level HIV/AIDS Committee will be an important component of supporting sub-national responses. DACs may be coordinated by the local government, or they may be independent committees that operate under the NAC (or provincial level). The following three models illustrate different approaches to coordinating the sub-national response—but they each have the same mandate to support and coordinate local responses (refer to Box 16.1)

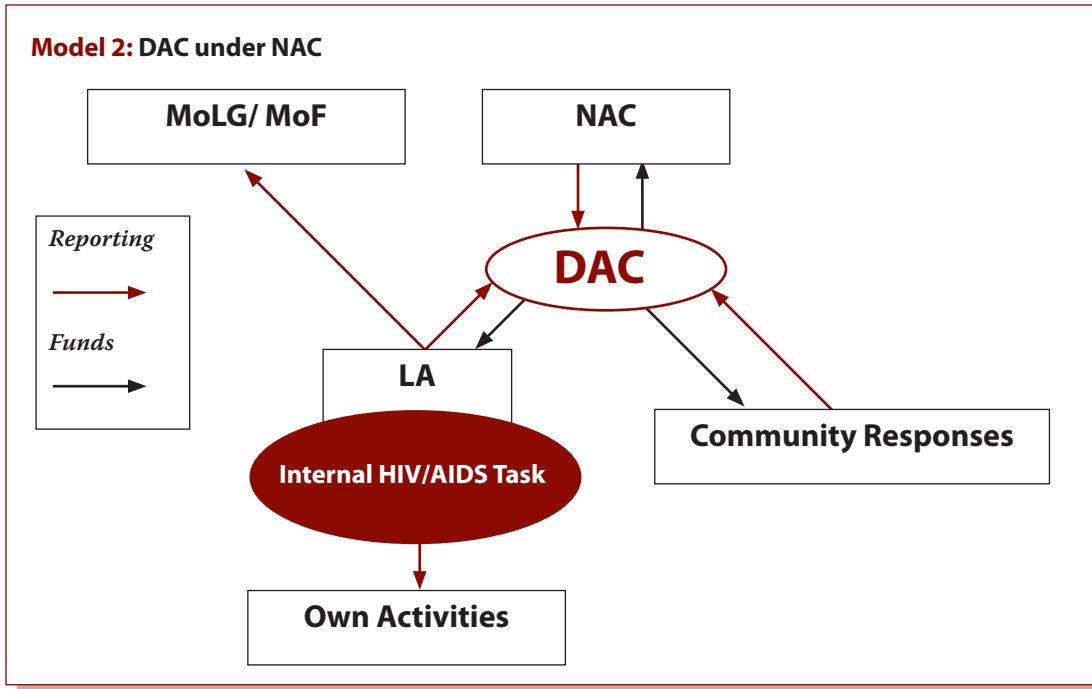
**Funds through NAC to LGA to DAC.** Local Government Authority coordinates sub-national responses to HIV/AIDS through DAC as planning and implementation mechanism. The DAC plans, coordinates and funds civil society’s responses. Funds for LGA’s own activities do not flow through the DAC but the sharing of planning processes and information is important.



In Model 1, the local government takes on the role of the primary conduit for sub-national funds (for community responses and own-activities). The DAC, in this scenario, is a multi-stakeholder committee that functions as a project-management unit (under the LGA) to coordinate the community responses. The Internal HIV/AIDS Task Team is comprised of focal points of local government departments and is responsible for coordinating the local government own-activities (workplace policy, mainstreaming, etc.). This model is the most advanced and most effectively integrated into existing local institutions and requires a local government that can carry out these functions or acquires the capacity quickly.

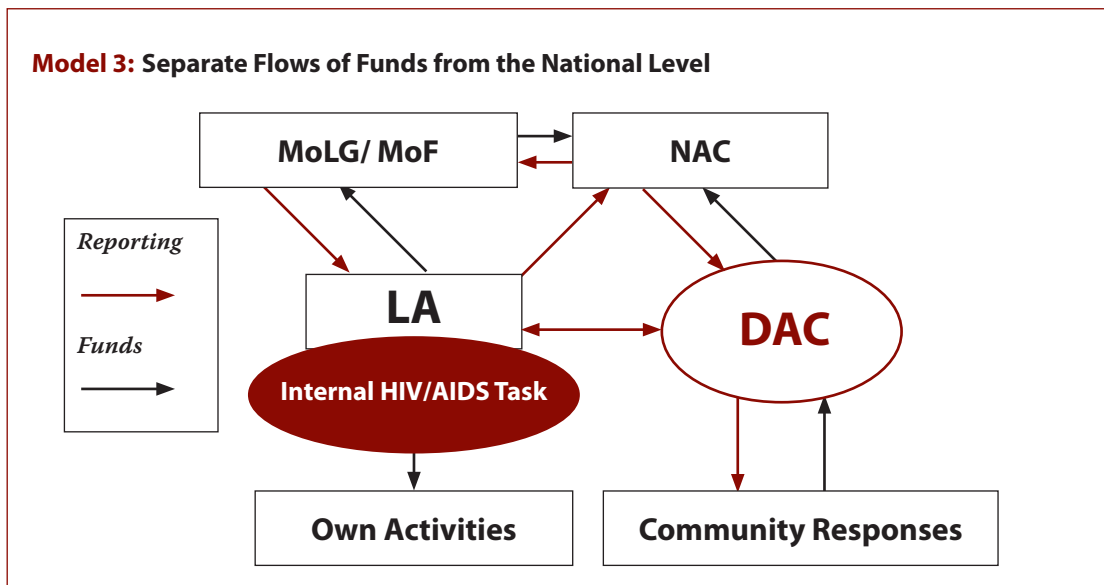
<sup>24</sup> The DAC is used here as a generic term to refer to the committee that is tasked with coordinating the lowest level of a sub-national response.

**Funds through NAC to DAC** which coordinates sub-national responses to HIV/AIDS. The DAC coordinates all activities funds go to DAC for civil society response and to Local Government Authority for its 'own-activities'.



In Model 2, the DAC is a multi-stakeholder committee that includes representatives from the local government, but functions as an independent project-management unit (under the NAC or Provincial level committee) to both coordinate community responses as well as review applications from and provide support to local authorities in carrying out their own-activities.

**Funds flow from NAC to DAC** for coordination and funding of civil society responses. Funds flow from MoLG/MoF to LGA for "own activities" under public sector response. DAC and LGA should liaise at local level through DAC.



In Model 3, there are two distinct funding streams—one for local authorities to conduct own-activities (funds likely channeled through the Public Sector Component of the NAC) and one for the DAC to coordinate community responses. This model is not ideal as activities may not be effectively coordinated between the DAC and the local government and deconcentrated public sector responses through Ministries are often slow and inefficient.

## 5. National support for sub-national responses

The following table summarized some of the key government and supporting institutions that may be involved in a decentralized response to HIV/AIDS.

**Table 16.2**

<b>Government Institutions</b>	<b>Provide the policy framework and the structures to support decentralized responses</b>
National AIDS Council	<ul style="list-style-type: none"> <li>* Ensure that all levels of government are referenced and supported in the National AIDS Plan</li> <li>* Support or lead capacity building function for Local Governments that are taking on new responsibilities to address HIV/AIDS. Facilitate or lead partnership for capacity building activities.</li> <li>* Support development of clear guidelines for appraisal and reporting of all sub-projects</li> <li>* Clarify procedures and policies relating to funding streams for local authorities</li> </ul>
Ministry of Local Government/ Urban Affairs	<ul style="list-style-type: none"> <li>* Ensure that all LGA are encouraged to address HIV/AIDS as part of their mandate</li> <li>* Support procedures for local authorities to undertake impact assessments on HIV/AIDS</li> <li>* Coordinate and support frameworks of monitoring and evaluation (on HIV/AIDS and other topics)</li> <li>* Integrate HIV/AIDS into decentralized planning and capacity building activities (linked to intergovernmental transfers)</li> <li>* Identify and support capacity building needs of LGA in addressing HIV/AIDS</li> </ul>
Local Government Authority	<ul style="list-style-type: none"> <li>* Provide leadership in promoting HIV/AIDS initiatives, and fighting stigma</li> <li>* Establish workplace policy for local authorities</li> <li>* Conduct local situation analysis to identify local priorities and needs of local stakeholders</li> <li>* Mainstream HIV/AIDS into LGA activities (in each department)</li> <li>* Coordinate local responses (both in public sector as well as among civil society organizations)</li> <li>* Integrate HIV/AIDS into development planning and monitoring</li> </ul>
Supporting Institutions	Provide support to decentralized responses (i.e. capacity building, information sharing, etc.)
Local Government Association	<ul style="list-style-type: none"> <li>* Support networks for information sharing among local authorities addressing HIV/AIDS</li> <li>* Facilitate with MoLG, NAC and local authorities in addressing policy and capacity building issues relating to HIV/AIDS at local level</li> </ul>
AMICAALL <sup>25</sup>	* Provide leadership and advocacy networks for mayors and possibly act as Lead Facilitator in Local Government Response (normally in alliance with LG Association)
Local Government Training Institutes	* Integrate modules on HIV/AIDS into existing trainings for local authorities
NGOs (that provide capacity building for LGAs)	* Support local authorities in addressing planning, management and coordination challenges in developing and implementing HIV/AIDS responses

<sup>25</sup> AMICAALL is the Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level, an African regional organization, which provides assistance to local governments in Africa, inter alia, to establish HIV/AIDS programs that can be funded by internal resources or submitted for funding to external donors such as MAP. See [www.amicaall.org](http://www.amicaall.org)

## 6. Capacity Building for sub-national responses

A key step in designing and supporting sub-national responses to HIV/AIDS is to identify at the outset an organization or individual that can act as a local coordinator/facilitator to provide the technical support to raise awareness in Local Governments, assist in planning HIV/AIDS programs and facilitate access to national funding and information sources, including NACs. (Assistance in establishing this facilitation may be requested from specialized organizations such as AMICAALL – see footnote 6.) As far as possible, this facilitator should be located in an organization with the mandate to build and monitor LG capacity on an ongoing basis, such as the Local Government Association or MoLG, and report to the NAC. Locating them in NAC is also a possibility. Funding for the facilitator would preferably come from the MoLG or LGA but NACs may need to finance this position in the short-term. Person should be sufficiently qualified and full-time.

## 7. What is expected of the District HIV/AIDS Committees or Councils?

Depending on what structure of sub-national response is used the functions of the DAC/LA will vary.

### Functions for Community Responses & Local Coordination

- Develop consolidated district HIV/AIDS workplans that outline priority issues to be addressed, and include both civil society responses as well as decentralized public-sector activities and LGA own-activities.
- Work with other partners (e.g. Associations, MoLG, NAC) to identify sources of funding and technical assistance to elaborate local sub-projects and apply for funding from NAC/others
- Prepare and implement a transparent communication strategy on procedures (including no. days per step) for grant application and approval process.
- Identify and apply for capacity building support within the DAC, LGA, and CSOs. This may include elements of financial management and procurement, strategic planning, monitoring and evaluation, and proposal development.
- Appraise community subprojects to ensure that they meet minimum requirements (are they legitimate organizations, and are the services they are offering needed and cost-effective) and that basic financial management and procurement aspects are clear.
- Consolidate expenditure statements and preparation of periodic financial reports (also see Chapters 13 and 14 on financial management and disbursements).
- Collect and compile reporting from all grant recipients (from CSOs, and LGAs) and establish coordinated monitoring and evaluation. (see Box 16.2)

### Functions for supporting Local government Own-Activities

- Support the development of an Internal HIV/AIDS Task team (comprised of focal points from each department)
- Develop guidelines for the development, submission and review of LG Own-Activity Workplans for Mainstreaming and Workplace Policy
- Integrate LG own-activities into District Development Planning (produced by LG for submission to MoLG/MOF) and/or district HIV/AIDS workplans (produced by DAC for submission to NAC)

#### Box 16.1: Procurement Management

The sub-national level committees would follow the procurement procedures set out by the government/NAC which have been agreed with the funding agencies during project preparation.

There are two types of procurement they would undertake:

- (a) procurement related to operational expenditures and consumables including hiring of consultant services, firms, NGOs and individuals
- (b) contract management of the community grant component. Also refer to Chapter 15 on procurement;

*NOTE: The MAP resources from NAC/NAS level can be used to train sub-national committee personnel in the basics of procurement planning and management, including appraising and monitoring procurement activities carried out by subproject implementers*

**Note: If Local Authorities are to be the conduit of funds for community responses in addition to their own-activities, additional functions will be required.**

## Management Functions

Whether the DAC or the LGA is the central coordinating body, they will need to be able to do the following:

- Manage a bank account (for example, the district accountant, or an accountant hired under the project as an individual or through a financial management firm).
- Prepare periodic financial and activity monitoring reports (also see Chapters 19 and 20 on financial management and disbursements).
- Conduct simplified procurement management (see Box 16.1)

In order to effectively carry out the above tasks, the DAC and/or LA must have one or more permanent or semi-permanent staff whose TORs include these activities and where they are given some additional resource to support their activities. Overburdening voluntary members can affect morale, slow down activities and undermine project management. In addition, in many cases it may make sense to contract out certain activities to large NGOs or private sector partners (e.g. in Uganda, large NGOs are contracted to assist in the appraisal and reporting on community sub-contracts.)

## 8. Funding mechanisms for local governments

### Box 16.2: MONITORING and EVALUATION

- All national and sub-national entities should be responsible to report periodically on three aspects of project implementation: (a) physical implementation; (b) financial status; and (c) monitoring of program activities;
- The frequency, content and format of the reports should be agreed during MAP preparation and revised as suitable during implementation;
- The sub-national HIV/AIDS committees should report on the activities carried out since the last report including financial statements, and on the subprojects processed and respective amounts disbursed.
- The Local Government Handbook provides a useful M&E checklist that can be used as a baseline for activity and process monitoring without the need for complex systems/data collection.

Various options for financing the capacity building and LG own-activities are available within the typical MAP component structure depending on the specific country. Under MAPs, LGs are fully eligible to (a) access funds from the Public Sector Component, and/or (b) access funds from the Grants Fund as the LGAs and DACs will include LG and Civil Society actors in their proposals. The latter usually allows for simplified fiduciary procedures which may have the flexibility appropriate for local governments.

## 9. Lessons learned and recommendations

- **Local Governments should move forward quickly** to prepare HIV-AIDS programs both for their own staff and families and for the many clients served by local governments. So clients may be served by local governments only while others require coordination with other agencies, particularly line ministries such as education and health.
- **A National partnership approach is necessary** for coordinating local responses and capacity building – Ministry of Local Government/Decentralization, Local Government Association (LGA), AMICAALL Chapter, NAC, Donors, others. A lead facilitator must be identified among the partners and adequately resourced and mandated to spearhead the program.

- AIDS focal points in local government should be full-time and adequately resourced. The preparation of HIV-AIDS program usually require a process of **social assessment and program preparation** that is best done through employing local, specialized consultants whose services can be funded under the MAP.
- **Local Partnership approach is important** – Local Governments work with communities and CSOs to implement LG program and coordinate among local AIDS service organizations in public and private sector.
- **All partners should collectively decide who should channel funds to civil society and who to LG for their own activities and how to coordinate information and planning (ie. Choice of Models)**
- Local Government work plans (especially for capacity building for mainstreaming and work place policies) should **be eligible for funding under NAP, distinct from national ministry plans**. The mainstreaming activities themselves could be funding through the DAC or Sector Programs (second best option).
- Different program and capacity building actions are required for Local Governments to act as **financial management agents who channel funds to civil society**. This note does not deal in detail with this approach.
- **LG M&E should be integrated into national LG compliance and monitoring system** and/or NAP M&E System.
- **Local politics may influence** the proposal review process as well as the control of funds. This can be mitigated by having broad stakeholder membership and ensuring open meetings and publicly available accounts.
- **There are cases where decentralization at all government levels has encouraged the establishment of 'briefcase' NGOs/CBOs with diverse motives**. NGOs/CBOs have to demonstrate basic commitment to HIV-AIDS activities and subproject management skills. Priority maybe given initially to scaling up activities of existing/experienced NGOs/CBOs;
- **An integrated communications strategy should be prepared and implemented among the decentralized agencies at all levels** (national, regional/provincial, district and village); this should inform potential applicants of all eligibility criteria, procedures and timeframes
- **A simple and clear fiduciary (financial and procurement) reporting system (2-3 pages maximum!) should be developed** and implemented before the financing of the sub-project proposals in order to ensure appropriate and reliable accountability without unnecessarily burdening local organizations. Capacity enhancement in this area is eligible for MAP funding.



See sub-manual (CD-ROM) on Local Government Responses to HIV/AIDS: A Handbook (CD-ROM)



# Chapter 17

## Contracting Services

### 1. What is contracting services?

Contracting services is using the established expertise of public agencies (eg, Ministry of Finance and Ministry of Health), external agencies (e.g., NGOs), private firms, especially; accounting and management consulting firms, and other organizations to undertake basic project management and administrative functions such as financial management, procurement, disbursement, monitoring and evaluation, social assessments, and social impact monitoring, and subproject approval. Contracting services may be provided by a contractor within the NAS office or at another location.

### 2. Why is contracting services important?

- Enables implementing and oversight agencies to concentrate on core “coordination and facilitation” activities rather than project management;
- Expedites the delivery of benefits to target groups in cost effective ways;
- Involves more stakeholders and sectors of a country in project implementation.

### 3. What can be contracted out or contracted in?

The role of MAP projects is to deliver services to target groups as quickly as possible in the four core areas of prevention, care, treatment and mitigation and to empower local communities to implement projects for themselves. This may not be possible using the more traditional project implementation arrangements (for example, a typical Project Implementation Unit (PIU) structure) where the PIU undertakes all implementation activities. The NAC/NAS are new, and may not have the capacity, scale, or budget to meet stakeholder expectations for effective and swift project implementation. This may also be true of other service providers. One logical option is contracting all or some services from outside firms into the NAC/NAS structure to fulfill agreed core duties or functions.

Contracting services can be very cost effective. Competition in tendering will produce the best possible price, and in the course of the contract the firm will look for the most cost effective way of fulfilling its obligations. In the unlikely event that the incremental cost of contracting services exceeds the estimated NAS cost, time saved in implementation and the more rapid realization of benefits will likely far outweigh any additional cash costs. Experience with MAP projects provides ample evidence of this conclusion. Box 17.1 illustrates Kenya’s successful experience contracting part of its financial management tasks to the private sector.

#### Box 17.1: Kenya Example

Kenya’s NAS has appointed a Financial Management Agent (FMA) to disburse all project funds which target civil society. The cost of this service is equal to about 9 percent of the funds to be disbursed by the FMA. This cost is well below the overhead costs of many agencies and NGOs which undertake similar tasks. Additionally, and probably equally importantly, it releases senior NAS personnel from many of the day-to-day financial matters so they can concentrate on key program issues. FMA staff that are not located in the field have their offices at the NAS. They participate in regular NAS operations and management meetings and it is clear that they are transferring financial management knowledge to regular NAS personnel. FMA also pays rent to NAS which helps defray overhead costs.



As HIV/AIDS overwhelms public systems, contracting services is a way of bringing in reinforcements. By involving more people and organizations in the struggle, it reduces the work that any one of them has to bear. Contracting services promotes an efficient division of labor. Many tasks are so specialized or repetitive that they are best carried out by entities that have developed that specialized expertise. Most of these tasks having nothing to do with HIV/AIDS; they include such detailed (and mundane) tasks as financial management and procurement. Delegating this work to those who know it best liberates public officials to perform the HIV/AIDS-specific functions that they alone can fulfill (such as setting policy and improving coordination).

NAS officials sometimes fear that contracting for services will mean a loss of control. In fact, the opposite is true. Contracting actually increases NAS's control. When a NAS purchases services from a contractor, it can specify in the contract precisely the nature, level, mix, and service standards it expects. The contractor has an incentive to perform well, both to ensure renewal of the contract and to enhance its commercial reputation, given the high profile of national HIV/AIDS programs. If the contractor fails to perform, it can be held legally responsible for any resulting delay or damages, and NAS can terminate the contract. By contrast, when a NAS depends on in-house (public sector) providers, there are generally no service standards, and NAS has neither the legal recourse for substandard performance nor authority to terminate the provider. Given the rigidity of most civil service systems, this leaves NAS at the mercy of a single provider.

### Some of the key services of MAP projects that may be contracted are:

**i. All or part of the *financial management system (FMS) requirements, disbursements, and internal audit. This may be done:***

- Entirely- for example, all financial management and disbursement services throughout the country.
- Functionally- for example, all disbursements, maintenance of the project general ledger, internal audit, etc.
- Geographically- for example, all services in a particular province.
- According to the level of project decentralization- for example, all FMS for NGO intermediaries, or all FMS for local communities.
- According to the specific services needed in any given financial management environment in regional or local project administration.
- A combination of any of the above.

Examples of successful contracting services in MAP projects in this category include:

- A comprehensive package of financial management services including accounting services and disbursement services to the private sector in Senegal;
- Accounting and most other traditional project management unit services to a sector PIU in Cape Verde;
- Disbursement services for civil society grants to a private firm in Kenya;
- NAS accounting to the Ministry of Finance in Zambia.

**ii. All or part of *procurement management. This may be done:***

- Entirely- for example, all implementing agencies for all goods, equipment, works, and consulting services;
- Geographically- for example, all procurement in a given geographic area;
- According to the level of project decentralization- for example, for all intermediary service providers;

- According to a financial threshold level- for example, all procurement over say \$10,000 or equivalent in local currency;
- According to specific procurement items- for example, all goods;
- according to the specific services needed- for example, the services of a procurement specialist in the NAC/ NAS central office;
- A combination of any of the above.

An example of contracting services in MAP projects in this category includes the Cape Verde MAP which contracts all procurement services.

**iii. *Community and civil society initiatives component management which may involve:***

- Assistance to local communities with preparation of proposals;
- Receipt of proposals;
- Evaluation of proposals and site visits where necessary;
- Approval of proposals either across the board or according to a financial threshold level;
- Implementation supervision;
- Disbursements;
- All, or a combination of any of the above, according to geographic location, or according to sub-project theme.

Examples of successful contracting services include: both the Senegal and Sierra Leone MAP projects contract out application reviews and the technical appraisal of sub-projects, and several countries have contracted out program mobilization and coordination to regional NGOs.

**iv. *Community mobilization which may include:***

- Identification of community needs.
- Preparation of proposals.
- Managing funds;
- Measuring impact.

**v. *Social marketing of condoms nationally or regionally.***

**vi. *Sensitization and HIV/AIDS social impact assessments and capacity program development in:***

- National ministries and agencies.
- Decentralized ministries.
- NGOs.
- Community Service Organizations.

**vii. *Monitoring and evaluation:***

- By geographic region or by other stratified populations
- The collection of baseline data
- The measurement of impact of project interventions

An example is Senegal, which sub-contracts the surveillance aspects of monitoring and evaluation to the Ministry of Health.

- viii. **Mandatory *financial audit* to the private sector rather than through the government auditor.**
- ix. ***Procurement audits.***
- x. ***Maintenance services for equipment and vehicles.***

As with many other aspects of implementing MAP projects, one model or method of contracting services does not necessarily fit all situations or projects. However, one of the four access criteria for countries to benefit from MAP funding is the willingness to use exceptional implementation procedures in the war against HIV/AIDS. “Exceptional” is defined as: (i) channeling money directly to beneficiaries, especially communities; (ii) contracting aspects of program management and administration to avoid creating new bureaucracies and to accelerate program implementation.

#### 4. Lessons learned and recommendations

- **The Map Progress Reviews in 2001 and in 2004 both concluded that the greatest danger to rapid and sustainable action is the tendency for NAC/NAS to act like bureaucracies**, to build up in-house capacity rather than to contract services, and to empower themselves rather than empowering units in ministries, civil society, and communities. One way to overcome this problem is to contract service functions on the basis of efficiency and effectiveness rather than assuming the NAC/NAS is entitled to become a large bureaucracy.
- **MAP program implementation is more successful in countries where the NAC/NAS has defined its role** as “facilitation and coordination” rather than as “control and implementation”.
- **Contracting services of the impact assessment and program development of government agencies is critical if programs are to be effective and timely.** All countries have a multitude of public organizations which have enormous potential to impact positively on the war against HIV/AIDS. Many of these agencies do not have the capacity to undertake their impact assessment or program development so, as a consequence, many opportunities are lost. The assessments and program development should take place during project preparation. Funding for this may come from a PHRD grant, Project Preparation Facility, or retroactive financing. Agencies in on-going MAPs, which have been determined to have inadequate assessments and programs should contract out this assessment forthwith. The process of impact assessment and program development is essential for building commitment within a public agency especially if it is undertaken by consultants who are familiar with the agency and its business and have the agency’s confidence.
- **Contracting services has taken several different forms** from comprehensive contracting of all essential services in Senegal (FMS, disbursements, program approval, monitoring and evaluation etc.) to selective service contracting in other countries of one or several of the functions described above. More contracting of services facilitates program implementation.
- **Contracting financial management including disbursement services has been found to be the most effective way of managing project funds and complying with donor fiduciary requirements.** However, there is a need for NAC/NAS to provide clear information about MAP and provide guidelines and information on the operations, flow of funds, and reporting requirements to both civil society and other stakeholders in the public sector, and to retain overall responsibility for overseeing implementation.



# Chapter 18

## Supply Chain Management in HIV/AIDS Programs

### 1. Introduction

HIV/AIDS prevention, care and treatment, and mitigation programs cannot succeed without a reliable and consistent supply of condoms, high-quality drugs, HIV test kits, laboratory reagents and medical consumables, etc. needed to support service delivery. Comprehensive and, effective prevention diagnosis, counseling and treatment programs sometimes require more than 120 distinct products. While the efforts to scale up HIV/AIDS interventions include increased investment in commodity procurement, not enough attention has been focused on the supply chain responsible for the management and delivery of these commodities.

The sheer volume of commodities required to provide HIV/AIDS services to initially thousands, and eventually millions, of people can be staggering and complex to manage. Furthermore, some of these products are new to the health care system and some require special handling such as a cold or a cool chain.

Investing in effective and efficient supply chains can maximize the use of resources, reduce waste, improve quality of service, and ultimately, ensure that customers receive the products they need and donors are persuaded to provide even more resources.

### 2. What is a Supply Chain?

The term supply chain describes the links of many organizations, people, and procedures involved in getting commodities to the consumers. Typically a supply chain would include partners from manufacturing, transportation, warehousing and service delivery. Together, these organizations orchestrate the flow of products, information and funds.

A key ingredient of a successful supply chain is that partners are focused on improved coordination and information-sharing, but more importantly, all of them are focused on serving the end-customers. Businesses around the world have shown that customer-driven<sup>26</sup> supply chains benefit all partners and consumers.

As shown in Figure 18.1, in health care, the supply chain partners usually include manufacturers, pharmaceutical companies, donors or funding agencies, procurement agents including UN agencies, ministries of health, health administrative units, central, regional and district medical stores, the private sector, NGOs and service delivery points (SDPs).

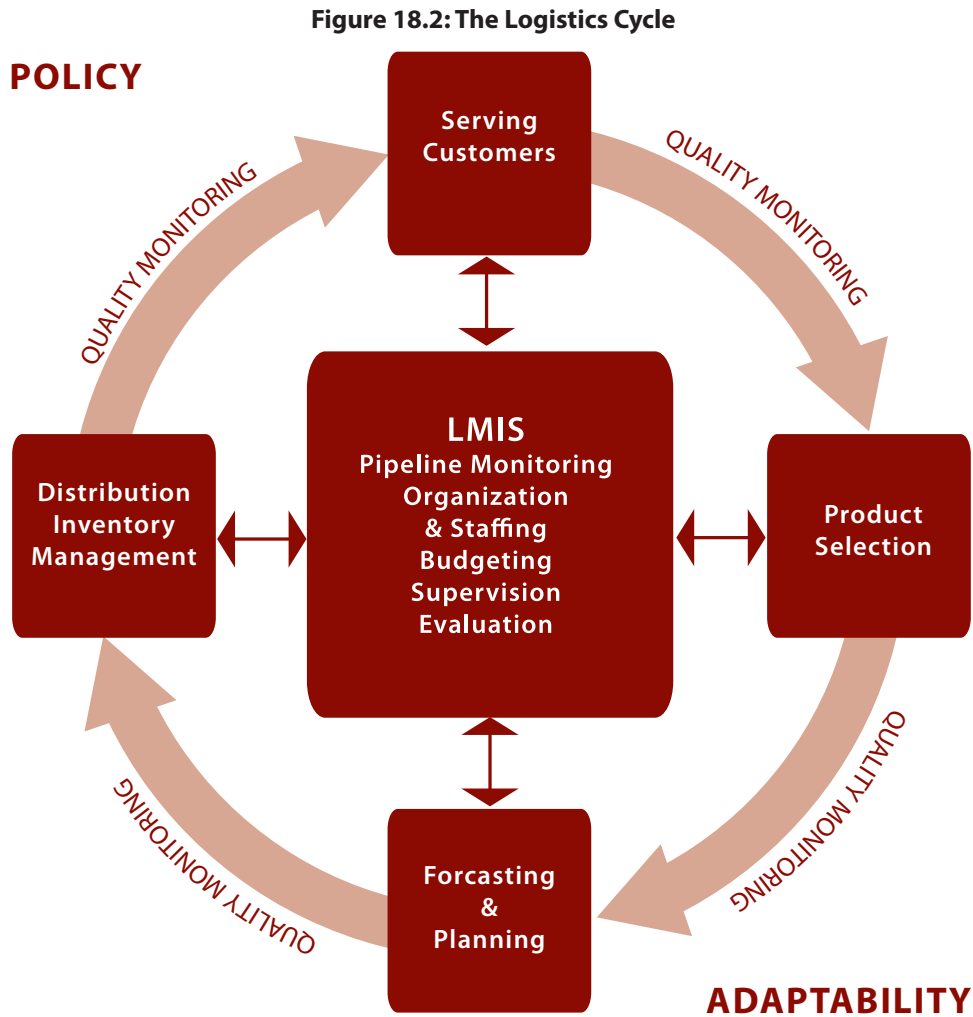
**Figure 18.1: Supply Chain Partners**



<sup>26</sup> All the partners of the supply chain are focused on the customer.

While the term supply chain describes the inter-relationships among organizations, logistics<sup>27</sup> refers to the specific functions that needs to be carried out by each of the supply chain partners such as selecting products, forecasting demand, procuring/ ordering, storing and delivering from one level to the next until the commodities reach the clients.

Figure 18.2, describes all the activities and resources that are continually needed to operate effectively. This is also known as the Logistics Cycle.



Source: DELIVER/John Snow Inc

Striking the balance between maximizing service and minimizing the costs of the system is a continuous challenge for health program managers. However, because of the high risk of drug resistance due to intermittent treatment, ensuring a full and continuous availability of health products is absolutely critical. On the other hand, maintaining excessive levels of drugs can be very costly.

Regardless the type of supply systems used for getting the commodities to the consumer, whether managed through the public sector or the private sector, the goals of commodity availability and accessibility are dependent on good logistics – the ability to accurately forecast, procure, transport and deliver the right goods, in the right quantities, in the right condition, to the right place, at the right time for the right cost. Even for those unfamiliar with the technical components of the logistics process, these goals would seem self-evident.

<sup>27</sup> While the concepts of supply chain and logistics are different, in practice, these terms are often used interchangeably.

Table 18.1: Importance of Logistics Functions

Logistic cycle	This step is important because:	What may cause delays in the step?
Product Selection	Specifies the products that need to be purchased	Lack of clinical protocols, guidelines or policy
Forecasting	Projects the total requirements for the short, medium and long term	Lack of data on the consumption patterns and on stock levels in the country
Procurement	Enables the products to be purchased	Poor specifications, incomplete projections, unclear procurement procedures
Storage	Stores supplies according guidelines in order to ensure that the shelf life of the product is well-maintained	Storage staff not informed of the procurement in the pipeline
Inventory management	Enables program managers to know the stock levels	Lack of a system in place, lack of stock cards
Transportation	Transports the commodities to its destination	Transport procedures unclear, commodities transported as a secondary item as part of other programs, transport managed on an ad-hoc basis
Re-supply	Enables service providers to get refills	Lack of procedures for the re-supply process.
Serving customers	Serves patients and improves health outcomes	Lack of availability of products

### 3. Why is supply chain management important?

Supply chains help achieve the desired program impact. These include:

- Increases program impact and decreases drug resistance through consistent and reliable supply of essential products.
- Enhances quality of care by ensuring that the products are available for the services being delivered.
- Improves cost-effectiveness and accountability through reduction of loss and wastage.
- Increases customer satisfaction and brings rationality to the system.

In addition, each of the activities in the logistics cycle is also important, because the coordinated completion of each of the activities enables the products to be delivered to consumers.

### 4. What is needed for effective supply chain management operations?

Effective supply chain operations requires:

#### Policy Support

Policy makers need to understand the vital role played by logistics; value the tangible benefits and ensure that all customers are reliably supplied. A key to ensuring policy support is to include a “logistics champion” in the National AIDS - Program secretariat (or coordinating agency).

**Customer Focus**

The focus of the logistics operations should be on satisfying customer needs. A key to achieving a customer focus is for all the staff involved in the national HIV/AIDS programs to know their customers and their needs. For example, a successful logistics system will ensure that products that are simple to use and can be administered on site are delivered to locations that are convenient to the consumers.

**Strategic Planning**

Supply chain functions should be viewed as a mission-critical function that adds value to the outcomes of the health interventions. A key to achieving strategic planning is to ensure that an assessment of the supply chain is completed early in the process of developing the national HIV/AIDS program and the results are used to design and strengthen the system. A performance measure system of the logistics functions which assesses timeliness of deliveries, availability of products at the service sites (measured as percentage product availability or stockout rates), reduction of waste, etc. should be established and should drive the system.

**People and Money**

Investment of money and of trained people is critical for the effective management of a logistics system. A key to achieving an effective logistics systems is to invest at least 15 – 20 percent of the commodity cost in logistics<sup>28</sup>. As the systems become more efficient, the overall cost of the system should go down. Staff skills in logistics activities should be appraised and plans made for improving capacity, if needed.

**Logistics Management Information System (LMIS)**

Reliable, accurate and timely logistics information should also drive the system. Three key logistics measurements are essential for day to day management of the supply chain: consumption, stock on hand and losses and adjustments. This information is not only important for daily stock management, but, aggregated and analyzed, enables managers to project future needs and to better negotiate with and manage suppliers. A key to achieving improvement in the management of the supply chain is to design and implement a basic manual LMIS that reports these key essential measurements

**5. How to ensure that supply chain planning is adequate?**

Logistics systems or supply chain management systems can be continually improved to provide better customer service, improve efficiency or effectiveness. However, there are four key areas that should be addressed early in the process of planning.

**Product Selection**

The first step to supply chain planning is to know the initiatives the national AIDS program will support and the commodities that will be required to meet that service delivery. *Figure 18.3:*

Generally, the framework for a comprehensive national HIV/AIDS program illustrates the range of services, commodities, and infrastructure required for service delivery. Each of the components of the program should be considered as part of a continuum of care for people living with HIV/AIDS and for HIV/AIDS prevention.

**A Comprehensive HIV/AIDS Program**

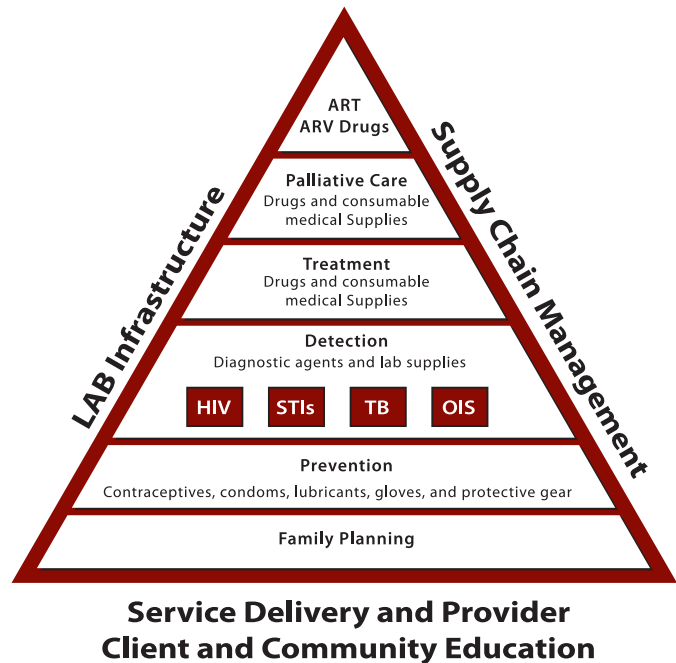


Figure 18.3: Systems and medical services for a comprehensive HIV/AIDS program

<sup>28</sup> According to the health care industry analyst reports, the cost of logistics is estimated from 15% to as high as 45% of the cost of commodities or hospital expenditure. Data on the cost of operating healthcare logistics systems in developing countries currently is lacking.

Selecting the right product is essential. Standard treatment guidelines, essential drugs list (EDLs), HIV testing protocols and national formularies should serve as a basis for product selection. Criteria for product selection is usually based on the standard guidelines provided by the World Health Organization<sup>29</sup>(WHO).

In addition, to the standard WHO criteria, product choice should also take into account the implications for logistics management.

### Logistics considerations for product selection include:

- Standardize and limit the number of commodities that are duplicative. A limited number of products makes the logistics functions easier to operate.
- Reduce commodities that require additional accessories such as semi-rapid tests.
- Purchase commodities that ease the burden on the provider and the client. For example, use of rapid assay HIV tests that allow for same day testing and confirmatory testing at the same site so clients don't have to make a return visit at a later date to receive results.

### Planning and Forecasting<sup>30</sup>

Where historically data are limited, it is difficult to accurately forecast needs. Quantification of HIV/AIDS commodities requirements should take into account the following factors:

- Treatment protocols, norms and standards.
- Estimates of numbers of beneficiaries to be served.
- Service absorptive capacity such as staff skills, infrastructure, etc.
- Laboratory infrastructure and capacity for services requiring laboratory diagnostics (e.g. treatment of TB, OIs and ARVs).
- Status of the supply pipelines and stock levels in-country.

New or expanding HIV/AIDS programs and rapidly changing technologies make it particularly important for supply chains to be able to adapt to changing needs. To ensure an effective and timely response to changes in demand, it is critical to:

- a) Initiate/establish a logistics management information system (LMIS) that captures the three essential data items; – consumption, stock on hand, and, losses and adjustments and that routinely aggregates and analyzes these data at the national level, as early as possible in the project cycle.
- b) Ensure flexible procurement mechanisms that allows for changes in quantities and product formulations.
- c) Negotiate flexible delivery schedules with suppliers to adjust to program demands.

### Procurement

From a logistics perspective, uncertainty of forecasts, rapid change in technology and, shorter shelf life of some products, requires flexibility in the procurement<sup>31</sup> process that allows for purchasing of smaller quantities, more frequent deliveries and changes in product selection in order to take advantage of new and improved products as they become available. While the unit cost of this type of procurement may be high, delivered cost may be low as it reduces the risk of loss due to expiry, pilferage, or poor storage.

<sup>29</sup> These include: product's relevance to priority health problems; proven efficacy and safety in a variety of settings; quality of product; favorable cost-benefit ratio; and affordability.

<sup>30</sup> Refer to Technical Guide: "Battling HIV/AIDS: A Decision Maker's Guide to the Procurement of Medicines and related Supplies" Chapter 4- Product Selection, Quantification, and Quality Assurance, for more information

<sup>31</sup> Refer to Technical Guide: "Battling HIV/AIDS: A Decision Maker's Guide to the Procurement of Medicines and related Supplies" Chapter 5-Procurement and GOM Chapter 22 "Procurement of HIV/AIDS Medicines and Supplies", for more information



Commodities can be procured either by: (a) the National HIV/AIDS Program using National Competitive Bidding, International Competitive Bidding or Limited International Bidding methods (also see the chapter on procurement for other methods); (b) a Procurement agent like a private sector agency or UN agencies. The best procurement method will depend on the nature of the goods procured, capacity etc. It is important that flexibility and staggered delivery are included in the procurement, no matter which type of procurement method is used.

### Product Registration and Quality Assurance <sup>32</sup>

Product and supplier registration and quality assurance can take a substantial amount of time that can lengthen the procurement process and result in products being quarantined. Early in the procurement planning, the process of registration and quality assurance should be clearly outlined, streamlined and waivers should be obtained, if necessary.

### Distribution <sup>33</sup>

Distribution includes storage, inventory management, re-supply procedures and transportation. There are several ways in which products are delivered to the health care service providers and the consumers/beneficiaries. These include a public sector distribution system, a NGO managed system, commercial systems or a combination of some or all. In order to rapidly mobilize for scaled-up HIV/AIDS commodity programming, it is likely that many or all distribution networks may be used to get the product to the provider and client as quickly as possible. A key principle that could dramatically improve the distribution and inventory management is to reduce the number of intermediate storage points such as regional and district warehouses. This strategy would decrease storage and inventory costs required for the operation.

A major stumbling block to streamlining distribution networks in the public sector is that many of the supply chains mirror government administrative structures. Supply chains increasingly need to de-link from government administrative structures. This is even more critical for HIV products with short shelf lives as, every intermediate storage level, lengthens the pipeline, which increases the risk that the products will expire before reaching the provider and consumer.

The first step in gaining a better understanding of the efficiency and effectiveness of these distribution systems is to conduct an assessment, that identifies the limitations and challenges of each of the systems. In addition to the findings of the assessment, there are generic principles of distribution management that specifically impact the HIV products and should be universally applied.

### Storage

- Adequate and appropriate storage is available at the national level, and at every intermediate level down to the final customer.
- Procurement plans take into account storage capacity.
- Storage space is secure, especially for ARVs which are expensive and risk being pilfered.
- A cold chain system is in place for those HIV products that require it.

### Inventory management

- Max and Min inventory control systems are in place.
- FEFO (First Expiry-First Out) procedures are used when distributing products.
- Stock cards for record-keeping are used on a daily basis to manage inventory.

<sup>32</sup> Refer to Technical Guide: "Battling HIV/AIDS: A Decision Maker's Guide to the Procurement of Medicines and related Supplies" Chapter 4- Product Selection, Quantification, and Quality Assurance, for more information

<sup>33</sup> Refer to Technical Guide: "Battling HIV/AIDS: A Decision Maker's Guide to the Procurement of Medicines and related Supplies" Chapter 3- Managing the Supply Cycle for Better Outcomes, for more information

### Transportation

- Secure transportation system and procedures in place for transporting high-value commodities.
- Cold chain system in place during transportation for those products that require it
- Reliable, timely, scheduled delivery will bring confidence in the system and reduce hoarding behaviors.

### Re-supply

- Supply imbalances will inevitably occur if everyone in the system does not understand or adhere to proper re-supply procedures.
- A push system is a better approach when demand of the commodities exceeds supply<sup>34</sup>.

### Logistics Management Information System (LMIS)

- A well functioning LMIS is required if the logistics system is to operate effectively and ensure product availability to the consumer.
- Automated LMIS systems are even more critical due to the sheer volume of data expected to be generated in the management of HIV products<sup>35</sup>.

## 6. What are the Specific HIV/AIDS Program-Product Issues?

Table 18.2, outlines the specific issues related to the management of HIV products that bring added complexity to the existing logistics systems.

**Table 18.2: Logistics implications of HIV products**

Program	Logistics Complexity	Potential Solutions
Condom Distribution	Distribution of the condoms need to include non-traditional places such as bars, hotels, etc.	Consider segmenting the market, and using the commercial and or social marketing programs to complement the public sector.
Volunteer Counseling and Testing	Many of the reagents have a short-shelf life.  Semi-rapid HIV tests kits require additional accessories and bring an added management burden.  HIV testing is conducted off-site. This requires a reliable logistics system to transport blood samples, testing results and requires clients to make multiple trips to the service center.	Shorten the pipeline  Consider rapid-only tests  Consider rapid tests which can be used on site and provide same day results.
Sexually Transmitted Infections	Some of the STI antibiotics are used for other diseases, especially when the general essential drug system does not have enough supplies	Consider meeting the supply needs for both STI and other diseases.  Assist in developing a rationing strategy Improve rational drug use
Palliative care	The drugs and supplies for palliative care can be used for other diseases.	Consider meeting the total supply needs.  Assist in developing a rationing plan Improve rational drug use
ART	ARVs are costly  ARVs have to be managed in full supply, otherwise there is a high risk of drug resistance.  Cost of maintaining full-supply of products can be costly	Secure the logistics system.  Long-term financing needs to be planned for the ARV program  Streamline the logistics system

<sup>34</sup> Re-supply can be based on a “push” – where the higher administrative levels determines the order quantity; or a “pull” – where the system receiving the supplies determines the order quantity. Either systems can work, and one is not better than the other, if there is adequate communication and data flowing between the levels.

<sup>35</sup> Logistics systems have to be information based. The Logistics Management Information System (LMIS) is the engine that drives the supply chain. The data enables program managers to improve forecasts and procurement plans.

## 7. Lessons Learned and Recommendations

### Priority given to supply chain management.

- Countries normally underestimate the complexity, planning and resource requirements, and funding needed for proper supply chain management. As a result programs often get off to a poor start, angering beneficiaries and frustrating donors. Planning for and investment in supply chain management needs to be done at the start of program implementation.

### Contracting

- Contracting for many aspects of supply chain management should be considered as a priority not as a last resort.

### Finance

- Use of the commercial sector and market segmentation could enable governments to use their resources more strategically – providing free or subsidized supplies and services to the poorest clients or those at highest risk.

### Access

- Commercial or social marketing programs can be used to complement the public sector. It could also provide clients with an alternate outlet for getting supplies.

### Impact of health sector reforms

- For effective decentralization of logistics systems, staff at local levels need to be well trained and information sharing between levels is vital.
- Integration of supply systems needs to be well planned and executed. Process reengineering methodologies should be used to guide the process of system integration and simplification.

### Policy

- When launching a new HIV/AIDS program, collecting baseline data on logistics system capacity and performance can inform the design of the system and resource requirements. This data can also be used to advocate for sufficient resources and to monitor performance of the system over time in order to make adjustments as needed. Identifying and addressing the root cause of each problem requires an understanding of the situation particular to each country setting and adapting generic frameworks and processes to fit each country's needs.

### Product Selection

- A limited number of brands of rapid HIV test kits should be selected on the basis of their technical performance (high sensitivity and specificity); preference might be given to those that do not require cold chain storage

### Forecasting and Procurement

- The provision of sharps/safety boxes is required to ensure the safe disposal of contaminated sharps. Current supplies remain inadequate to meet the demand for safe disposal of infectious medical waste in health facilities.
- Flexible and staggered shipping schedules to allow more frequent and smaller shipments of HIV/AIDS commodities will maximize product shelf life, reduce product wastage, and avoid overburdening the in-country supply pipeline.

### Distribution: Storage, Inventory Management, Ordering and Transportation

- The high price of ARVs and the nature of their use for prolonging survival and improving quality of life of HIV/AIDS patients make ARVs more subject to pilferage and leakage to other markets. Therefore, strict monitoring of inventory levels and secure transportation and storage facilities will be needed. New procedures for handling ARVs should be as consistent as possible with existing procedures for handling high value or restricted access drug items in health facilities.

### Logistics Management Information System (LMIS)

- A well functioning LMIS is required if the logistics system is to operate effectively and ensure the availability of quality products at service delivery points. Close monitoring of product consumption and stock levels through routine reporting is particularly important for ensuring an adequate supply of quality products, responding to changes in demand, managing increased volumes of commodities, and minimizing pilferage and misuse. It is essential that the LMIS be designed and in place to collect, analyze and disseminate information on stock on hand, dispensed-to-user data and losses and adjustments before distribution of products begins.

### Product Use

- Clinical algorithms can help with the proper use of the products

### Medical Waste Management

- Planning and budgeting for the consistent use of auto-disable syringes helps ensure that injections are given with a sterile syringe and needle since these devices cannot be reused. Ensuring safe injections reduces the risk of iatrogenic transmission of HIV, as well as other blood-borne pathogens.
- The provision of sharps/safety boxes is required to ensure the safe disposal of contaminated sharps. Current supplies remain inadequate to meet the demand for safe disposal of infectious medical waste in health facilities.
- Bundling sharps boxes with the corresponding quantities of syringes/needles can ensure that the two are distributed together and in sufficient quantities.



# PART IV



Fiduciary Management





# Chapter 19

## Financial Management

### 1. Why financial management is important?

- To facilitate the delivery of large volumes of funding rapidly and transparently through the MAP;
- To satisfy fiduciary requirements that project resources are being used economically, effectively and efficiently for the purpose intended;
- To build stakeholders' trust in the MAP approach and its ways of doing business;
- To assist with the control of misappropriation and other corrupt practices;
- If finance is misused, accessing further funding will be difficult or unavailable.

### 2. What is needed for an effective financial management system?

#### Introduction.

Money makes projects happen and financial management and control is all about ensuring that money and other resources are used economically, effectively and transparently and are available where needed, on time, to meet project needs. Financial management comprises five basic elements, see Box 19.1.

Because of the nature of the MAP program and structure, MAP financial management and control, especially internal financial systems which are essential to good implementation, is more complex than in traditional investment projects. This is because of the different levels and financial channels involved in the successful implementation of a MAP. These levels are: first, the primary organization (NAC/NAS) which is responsible for overall project coordination, financial management, and administration; second, secondary organizations which implement and supervise programs on behalf of NAC/NAS; and third, tertiary organizations, or local communities, which implement subprojects at the local level. The cascading of funds down to these different levels also means that financial management and control must extend from the national NAC/NAS level to the community. Similarly, financial reporting must cascade back up from the community level, through district and other intermediate levels, to the national organization or the NAC/NAS.

#### Box 19.1: Financial Management

- Planning and budgeting
- Disbursement (see Chapter 20)
- Recording financial transactions
- Reporting financial transactions and physical progress
- Ensuring the integrity of internal systems and controls and financial reports. Providing an effective value adding internal audit mechanism and independent and effective external audit.



Many people consider compliance with financial management requirements a difficult and daunting task. These people also often believe that financial management, internal control systems, and audit rules make compliance issue worse. In fact, the opposite is true, particularly when the main financial management tasks are assigned to a trained and experienced specialist. World Bank financial management rules and requirements are specifically designed to provide projects with flexibility while providing sound financial control and maintaining the integrity of the program's objectives. MAP projects provide greater flexibility than most other Bank financed projects, particularly at the community or district level. While rules do obviously apply, they are relatively simple, few in number, very flexible, and can be easily accommodated, particularly with competent and trained people.

## Requirements for suggested financial management system

MAP programs are designed to follow the financial management rules of borrower / recipient governments and in consultation with donor institutions. The financial management system must ensure that: (i) record of project assets, liabilities, receipts, and expenditures are maintained in compliance with statutory and other requirements; and (ii) financial information is provided to facilitate project management and to improve project performance continuously. Table 1 at the end of this chapter provides a matrix of requirements for a suggested financial management system for a MAP at different levels of implementation . It is subdivided into three implementing categories or levels and key financial management elements. The number and type of implementing organizations in different MAPs will vary considerably but the three generic categories noted here should cover most possibilities. They are:

- Category A** Primary organizations such as NAC/NAS which are responsible for: (i) the maintenance and management of the Special Account(s) and other overall MAP fiduciary responsibilities; (ii) coordination of the MAP program; (iii) disbursing funds to secondary or intermediary organizations (Category B); and (iv) disbursing funds to communities (Category C).
- Category B** Secondary or intermediary organizations such as NGOs, private sector service providers, line ministries, or other decentralized service providers. These organizations are responsible for: (i) the maintenance of a MAP program bank account; (ii) the delivery of services; (iii) the disbursement of funds to communities (Category C); and (iv) supervision of the implementation of the MAP programs;
- Category C** Tertiary organizations- mainly communities which may not necessarily operate a bank account and which implement subprojects.

The attached matrix (Table 19.1) provides summary guidelines by category (A, B, and C) for:

- Accounting methods
- Books of account such as the cash book and general ledger
- Financial statements and reports such as the sources and uses of funds, balance sheet and income and expense statement, and statement of expenditures
- Reporting cascade
- Internal audit
- External annual audit, including the management letter

These guidelines are not exhaustive but they do provide a framework around which a project accounting manual or the financial management manual may be prepared.

## Other key considerations

Specific information of relevance to the financial management of MAPs which is not included in Table 19.1 is noted below. The Disbursement subject is addressed in Chapter 20.

## Financial reporting

MAP finances are administered by the finance and administration units of the National AIDS Council (NAC) or the National AIDS Council Secretariat (NAS). The NAC/NAS itself is responsible, or more commonly through sub-contracting to a special public agency such as the Ministry of Finance or a private firm, for project coordination, the management of bank accounts, the consolidation of all project reports<sup>36</sup>, and liaison among the government, the Bank, and other donors.

During project preparation the donors and the government or NAC/NAS should decide on the minimum financial data needs and agree to collect only these. It is highly desirable to avoid reporting the same data in different formats to satisfy different stakeholders. Report designers should consider either: (i) adopting the existing or government reporting formats and requirements; or (ii) adapting the government format to conform to standards for a program with MAP's complexity. Each transaction will be initiated on a source document such as a bill, receipt, or invoice. These documents will be evaluated before payments are made and filed for future audit.

## Financial Monitoring Reports

Recently the Bank simplified reporting requirements for its clientele. Financial Monitoring Reports (FMRs) are simply put, a comprehensive report of project expenditures and other financial data matched to the physical progress of the project and the status of implementing the procurement plan at a given date, which is usually end of a quarter and in some rare cases end of a six month period. Preparation of FMRs (previously PMRs – Project Management Reports) is mandatory for Bank financed projects approved after July 1, 1998. Some projects also use FMRs as the basis of disbursement (report based). FMRs are in that case playing a dual role i.e. a monitoring tool and a trigger for subsequent disbursement of Credit/ Loan/Grant proceeds to the implementing entity. FMRs are generally due within 45 days following end of the reporting period. NAC/NAS is responsible for putting the FMR in place before project implementation begins and the Bank's role is to monitor and review their use throughout the MAP's life.

FMRs need to provide sufficient information to establish: (i) whether funds disbursed are being used for their intended purpose; (ii) project implementation is on track; and (iii) budgeted costs are not exceeded. Financial information should be linked with information on physical progress and status of implementing the procurement plan and matched with the results of program monitoring and evaluation.

The format and content of FMRs should be determined during project preparation and agreed at negotiations. Adequate financial management arrangements, including the ability to produce timely FMRs, should be in place by project effectiveness. Examples of report requirements for MAP projects are included in Reference 13.2 (FMR Guidelines Reference A Sample 3) and they include: (i) Discussion of Project Progress; (ii) Sources and Uses of Funds Statement; (iii) Uses of Funds by Expenditure Type; (iv) Output Monitoring Report; and (v) Procurement report.

<sup>36</sup> Report formats must be clearly specified in the operations manual which should be agreed during project preparation. The timing for the submission of reports should also be specified.

## Auditing procedures and arrangements

### External Audit

**Scope of Audit:** All MAP projects are subject to annual external audits and these must comply with government regulations and the Bank's Operational Policies (OP/BP 10.02).

Examples of unqualified audit reports for an organization, for a project financial statement including a statement of expenditure, and for a special account are attached in references.

Audits of the Statement of Expenditures (SOE) – [where applicable] should be considered a part of the overall audit of the specific project financial statements but a greater effort of compliance checking is usually necessary. This is because withdrawal requests to the World Bank to transfer funds (from the Bank) to the Special Account may not be supported by documentation. The primary objective of this part of the audit is to ascertain that there is adequate audit trail behind each individual transaction that comprise the SOE based expenditures.

**Selection and appointment of auditor.** In principle, the use of independent audit firms should be encouraged where possible. Every effort should be made to appoint auditors who fulfill the criteria required by the International Standards on Auditing. Government auditors may provide an alternative to private auditors but their level of independence needs to be carefully assessed, as does their capacity to conduct a MAP audit given their other tasks. However, where available, reference should be made to the Country Financial Accountability Assessment (CFAA), which will have addressed this matter and provided recommendations for action. Where the government auditor is considered unlikely to have the required capacity to audit complex MAPs, effort should be made by government to contract the audit to an independent private auditing firm following Bank Guidelines for the Selection of Consultants.

Auditors should preferably be appointed early during the first year of project implementation to allow them an early opportunity to provide advise to the borrower on financial management systems and other implementation arrangements which involve financial transactions. During this period the auditor should also advise the borrower on the adequacy of the internal control procedures planned for the administration of the project.

NAC/NAS must advise the donors of the proposed auditors even when the government auditor is to be used and agreed at negotiation. The donor will review NAC/NAS nominee and issue its no objection if it believes the nominated auditor meets the project's requirements.

#### Box 19.2: Audit reports need to include:

- An assessment of the adequacy of the accounting and internal control systems to monitor expenditures and other financial transactions and ensure safe custody of project-financed assets;
- A determination as to whether NAC/NAS and other project implementation entities, communities or individuals have maintained adequate documentation on all relevant MAP transactions;
- Verification that expenditures documented to the Bank are eligible for financing, and identification of any ineligible expenditures;
- A separate opinion as to whether the financial statements of the Special Account(s) give a true and fair view of the financial position of the Special Account(s); and
- A management letter from the auditor which evaluates overall management performance within the NAC/NAS

### Internal control and internal auditing

World Bank guidelines do not require the establishment of an internal audit unit. But, because of the wide geographic spread and nature of implementation arrangements of the MAP, the establishment of a competent internal audit unit within the NAC/NAS or, perhaps more appropriately, the appointment of an external firm to fulfill the function is highly recommended but taking the cost of the service into consideration. An internal auditor should work within a well-defined framework of programs and reporting requirements.

### Implementing project financial management requirements

Two basic options are available: first, undertaking all financial recording and reporting functions under the project umbrella in the NAS using its own staff ; and second, contracting these functions to a suitably qualified firm of relevant professionals, (Financial Management Agent – FMA) which may also provide procurement services. In view of the emergency response nature MAPs are meant to support there is an even greater need to ensure integrity and competence in the financial management. To this end, use of FMA is highly desirable. So far there is a correlation because successful MAPs and use of FMAs.

#### Box 19.3: Role of the Internal Auditor

Typical matters which the internal auditor should appraise and report to top management include:

- The effectiveness of accounting, financial and operational controls, and any need for revisions;
- The extent of compliance with prescribed policies, plans and procedures;
- The reliability of accounting systems, data and financial reports;
- Methods of remedying weak controls or creating them where there are none; and
- Verification of assets and liabilities

## 3. Lessons learned and recommendations

Since the first MAP project commenced a number of key lessons have been learned:

- **Contracting financial management services** has been found to be the most effective way of managing project funds and complying with government and donor fiduciary requirements. However, there is a need for NAC/NAS to provide clear information about MAP and provide guidelines and information on the operations, flow of funds, and reporting requirements to both civil society and other stakeholders in the public sector;
- **Action plans for both financial management and monitoring and evaluation should be agreed from the outset.** Given the type of expenditures, multi-sector nature and geographic spread of the program, the accountability and discharge of fiduciary functions dictates different means of ex-post control. Accountability must be complemented by an effective monitoring and evaluation system. Accordingly it is important that the financial management and monitoring and evaluation are integrated and in place at the outset;
- **Capacity building within the financial management agency and the implementation of financial management concepts** and action plans has taken considerable time. This should be reduced and minimized in future through knowledge management and the reuse of systems and documents. Reuse of developed material, designed systems, and designed hardware and software specifications can save time and money;
- **Delay in the return of required documentation** and accounting for advances has reduced disbursements. Forms and other procedures need to be simplified further but a strong finance team headed by a well qualified professional with strong leadership capacity is necessary to ensure timely and complete accountability;

- **Implementation of FM systems** have largely been achieved at NACs but more attention is required at lower levels of the public sector and civil society where capacity varies.
- **Disbursement of funds** for the MAP has commenced but there is evidence that disbursements are slow. There is a clear need for the financial management system to include a timely monitoring system to detect actual and potential problems and bottlenecks;
- **Government financial and internal control systems** may be inconsistent and may not always be effective. Additionally, the concept of internal audit is not well understood and the design and capacity for the internal audit function is less than adequate. Early local advice and close liaison with government is essential to ensure satisfactory internal control and internal audit procedures;
- **Workshops in capital cities address generalities and will not detect and address crucial details which hinder day to day operations.** Financial management and procurement specialists must visit all ministries and regional entities to discuss and review financial management and procurement arrangements and issues;
- **Public sector accountability for MAP funds has been found to be inadequate in some countries.** Adequate training, strict procedures, follow-up and audit must be in place from the day the project becomes effective and ideally even before during project preparation;
- **Government budget ceilings on levels of expenditure may be problematic.** Project preparation teams should review this issue and resolve any possible conflicts with project objectives prior to project effectiveness.



See Annex 19 (CD-ROM) for further references and sub-manual on Financial Management

Table 19.1- Matrix of Suggested Financial Management Requirements

Category C Fund <sup>37</sup>		Category B Fund <sup>38</sup>		Category A Fund <sup>39</sup>	
Accounting method	<ul style="list-style-type: none"> <li>i. Use local language</li> <li>ii. Transactions recorded in simple formats</li> </ul>	<ul style="list-style-type: none"> <li>i. Use English/French language</li> <li>ii. Double entry bookkeeping system</li> <li>iii. Historical cost accounting</li> <li>iv. Computer or manual system</li> </ul>	<ul style="list-style-type: none"> <li>i. Complies with Bank Procedures BP 10.02</li> <li>ii. Complies with detailed procedures located in agreed individual project accounting manual</li> <li>iii. Use English/French language</li> <li>iv. Double entry bookkeeping system</li> <li>v. Historical cost accounting</li> <li>vi. Computerized system is essential</li> </ul>		
Books of account	<ul style="list-style-type: none"> <li>i. Cash issued register</li> <li>ii. Supporting documents retained</li> <li>iii. As few forms as possible to be used</li> <li>iv. Register of in-kind contributions maintained</li> </ul>	<ul style="list-style-type: none"> <li>i. Cash payment &amp; receipt book</li> <li>ii. Petty cash book</li> <li>iii. Stores records</li> <li>iv. Fixed asset register</li> <li>v. Cheques issued register</li> <li>vi. Cash issued register</li> <li>vii. Journal for non cash transactions</li> <li>viii. Fund replenishment register and register of expenses</li> <li>ix. general ledger</li> </ul>	<ul style="list-style-type: none"> <li>i. Cash payment &amp; receipt book</li> <li>ii. Petty cash book</li> <li>iii. Stores records</li> <li>iv. Fixed asset register</li> <li>v. Cheques issued register</li> <li>vi. Cash issued register</li> <li>vii. Journal for non cash transactions</li> <li>viii. Credit drawdown register</li> <li>ix. Register of SOEs</li> <li>x. general ledger</li> </ul>		
Financial statements and reports	<ul style="list-style-type: none"> <li>i. Monthly cash fund reconciliation statement</li> <li>ii. Fund Replenishment Request as required</li> <li>iii. Annual Cash Fund Reconciliation statement in predetermined cost categories</li> <li>iv. Annual Statement of In-kind Contributions in predetermined categories (see sample)</li> <li>v. Milestone report</li> </ul>	<ul style="list-style-type: none"> <li>i. Fortnightly and annual bank reconciliation statement</li> <li>ii. Fund Replenishment Request as required</li> <li>iii. Physical progress report</li> <li>iv. Fiscal year Balance Sheet if assets purchased or liabilities incurred within 1 month of year end</li> <li>v. Fiscal year Income and Expenditure statement in predetermined categories within 1 month of year end</li> <li>vi. Summary of Sources and Uses of Funds by agreed categories- including individual category C funds where practicable</li> <li>vii. Budget for next fiscal year 3 months before year end</li> </ul>	<ul style="list-style-type: none"> <li>i. Fortnightly and annual bank reconciliation statements for all bank accounts</li> <li>ii. Financial Monitoring Reports including:                             <ul style="list-style-type: none"> <li>a. Discussion of Project Progress</li> <li>b. Sources and Uses of Funds Statement</li> <li>c. Uses of Funds by Expenditure Type</li> <li>d. Output Monitoring Reports</li> <li>e. Procurement Report</li> </ul> </li> <li>iii. Disbursement documentation for replenishment (see Chapter 14 for specific details)</li> <li>iii. Special Account(s) Statement plus Annual Statement of Expenditure Withdrawal by agreed categories</li> <li>iv. Annual summary of Sources and Uses of Funds by agreed categories and individual funds where practicable</li> <li>v. Annual Balance Sheet for assets and liabilities within 3 months of year end</li> <li>vi. Annual Income and Expenditure Statement in predetermined categories within 3 months of year end</li> <li>vii. Annual External Audit Report and audit of the Special Account(s)- 6 months after year end</li> <li>viii. Annual Internal Audit Report within 2 months of year end</li> <li>ix. Budget for next 12 months by fund, 2 months before year end</li> </ul>		
Reporting cascade	<ul style="list-style-type: none"> <li>i. All fund activities</li> </ul>	<ul style="list-style-type: none"> <li>i. All Category B Fund activities financed directly by Category B Fund, plus</li> <li>ii. Sum of all Category C Fund activities funded by Category B fund</li> </ul>	<ul style="list-style-type: none"> <li>i. All Category A Fund activities financed directly by Category A Fund, plus</li> <li>ii. Sum of all Category B &amp; C Fund activities funded directly by Category A Fund</li> </ul>		
Internal audit	<ul style="list-style-type: none"> <li>i. Random review of financial management procedures</li> </ul>	<ul style="list-style-type: none"> <li>i. Annual review of financial management procedures</li> </ul>	<ul style="list-style-type: none"> <li>i. On-going process</li> </ul>		
External annual audit	<ul style="list-style-type: none"> <li>i. Random selection</li> </ul>	<ul style="list-style-type: none"> <li>i. Random selection for accounts with less than USD20,000 annual expenditure</li> <li>ii. Full annual audit for accounts with USD20,000 or more annual expenditure</li> </ul>	<ul style="list-style-type: none"> <li>i. Full annual audit</li> </ul>		

<sup>37</sup> Tertiary organizations- mainly communities which may not necessarily operate a bank account and which implement subprojects.

<sup>38</sup> Secondary or intermediary organizations such as NGOs, private sector service providers, line ministries, or other decentralised service providers. These organizations are responsible for: (i) the maintenance of a MAP program bank account; (ii) the delivery of services; (iii) the disbursement of funds to communities (Category C); and (iv) supervision of the implementation of the MAP programs;

<sup>39</sup> Primary organizations such as NAC/NAS which are responsible for: (i) the maintenance and management of the Special Account(s) and other overall MAP fiduciary responsibilities; (ii) coordination of the MAP program; (iii) disbursing funds to secondary or intermediary organisations (Category B); and (iv) disbursing funds to communities (Category C)





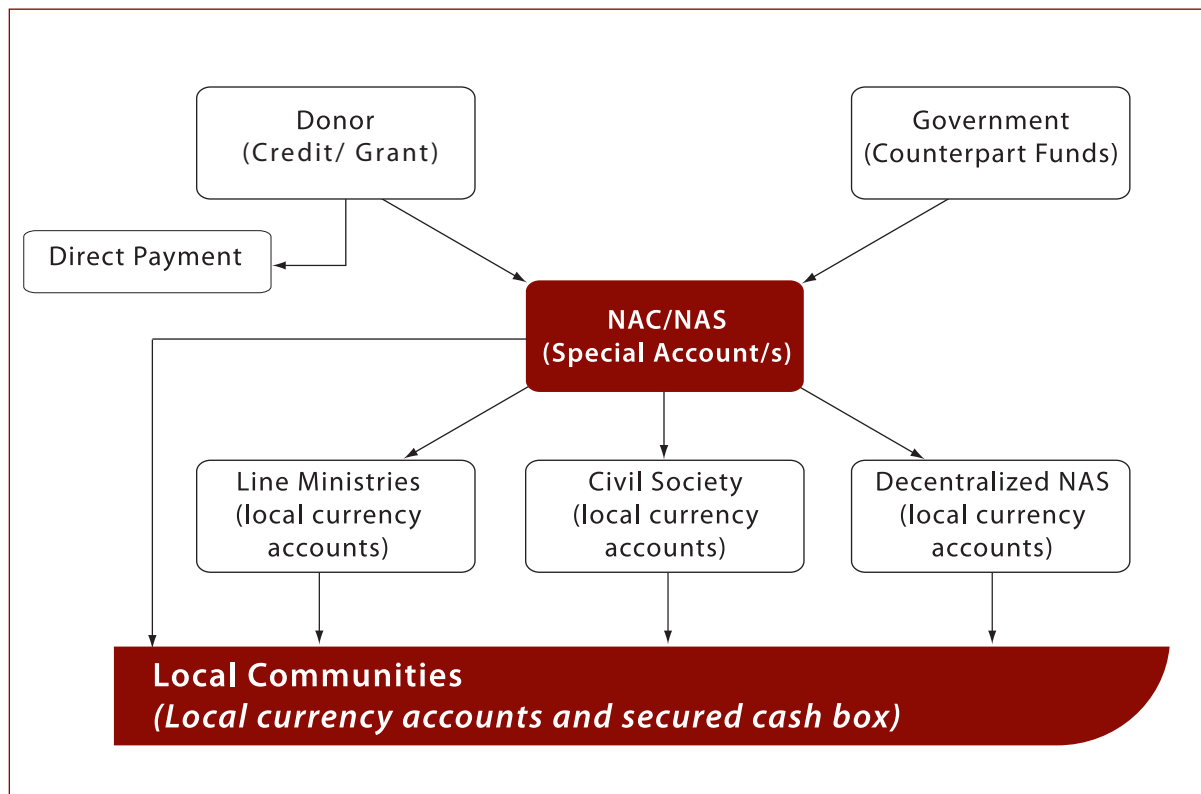
# Chapter 20

## Disbursement

### 1. What is “disbursement”?

Disbursement is the process of withdrawing funds from project related bank accounts or a cash box at the community level to pay for eligible project investments, operational costs, and to make and replenish project advances. Accounts include the project account(s) held by the donor, the Special Account, local currency accounts held by the NAC/NAS, NGOs and other intermediaries, and local bank accounts and cash held by local communities. In addition, there is possibility of direct payments being made by donors, such as IDA, to third parties on request of NAC/NAS. The chart below shows a simple flow of funds for a MAP project.

**Figure 20.1- Simple Example of Flow of MAP Funds**





## 2. Why effective disbursement is important?

- To get money as quickly and as simply as possible to beneficiary groups
- To satisfy lenders', government and beneficiaries' fiduciary requirements

## 3. What is required for an effective disbursement system?

### Introduction

Specific disbursement procedures should be developed with stakeholder participation for each country and sub-regional project based on the particular situation and design of the project. These procedures should comply with the disbursement policies and procedures of the financier (e.g., World Bank, government and other donors) and with the project objective of channeling funds quickly and simply to beneficiaries.

As was noted in the Financial Management Chapter, the number and type of implementing organizations may differ from one MAP to another. For simplicity, the same three generic models are used in this chapter: (i) primary organizations such as a NAC/NAS; (ii) secondary or intermediary organizations including NGOs and other decentralized service providers; and (iii) tertiary organizations which are mainly communities.

### Box 20.1: Disbursements

The key considerations for the disbursement procedures include:

- A link between physical progress and project expenditures
- An efficient and effective flow of funds to meet the needs of the project during a relatively short implementation period
- The need for a sufficient balance in the Special Account for decentralized and emergency activities
- The requirements of Financial Monitoring Reports of the World Bank funded reports.

As with financial management, many people see donor requirements for the disbursement of funds as being difficult and daunting. Similar comments apply here in the Disbursement Chapter as were noted in the Financial Management Chapter. In particular, World Bank disbursement policies and requirements are specifically formulated to provide projects with the utmost flexibility while providing sound financial control. MAP projects have even more flexibility than most other Bank financed projects, particularly at the community or district level. Disbursement procedures are relatively simple, very flexible, and can be easily accommodated, particularly with competent and qualified people. Disbursement and expense categories have been simplified for MAP. For NAC/NAS, and secondary or intermediary organizations which disburse funds on behalf of NAC/NAS, the disbursement categories are goods, civil works, consulting services & training, and operating costs. Communities do not have to categorize disbursements in the same manner. A simple list of expenditure items is all that is required.

### Disbursements to NAC/NAS for World Bank financed activities

Experience with MAP implementation has shown that disbursement management capacity varies among NAC/NASs. Two disbursement approaches are generally available under World Bank funded projects. NAC/NAS, or their agents, that are assessed as having adequate financial management capacity and have adequate procedures in place have the choice of using either of the two, i.e. "transaction-based" or "report-based" disbursements (see below). NAC/NAS, or their agents, that do not have sufficient capacity will use transaction-based disbursement procedures.

**Transaction-based disbursement** requires the submission of supporting documentation each time NAC/NAS request the disbursement of loan proceeds from the Bank (with the exception of the initial deposit to the Special Account). For reimbursements, or direct payments, supporting documentation is submitted with the withdrawal application before

disbursement is made. However, where use of Statement of Expenditures (SOEs) disbursement procedure allowed for specified type of expenditures, supporting documentation is retained at the NAC/NAS office for post review by World Bank staff and audit purposes at a later stage. Where SOEs are used, the eligible expenditures are summarized in a summary sheet, which is attached to a withdrawal application. For Special Account arrangements, supporting documentation for each disbursement is submitted with the next replenishment request. This enables the Bank to confirm past eligible expenditures before the next advance is made.

**Report-based disbursement** provides more flexibility. Using these procedures a forecast of project expenditures is agreed between NAC/NAS and the Bank covering the current and next reporting period. After this, the total disbursement requests not exceeding this forecast amount are payable by the Bank. Expenditures incurred are reported and submitted with the next FMR for review by the Bank to confirm eligibility. The bulk of the supporting documentation is retained by NAC/NAS for future review by Bank missions and for audit purposes. The expenditures are as much as is possible matched with the physical progress of the project. The FMR also gives a new forecast for the next two reporting periods.

The key differences between transaction-based and report-based disbursements are: (i) the timing of submission of expenditure reports ; and (ii) the linkage between expenditures and the physical progress of the project and status of procurement plan .

**Table 20.1** at the end of this chapter, gives details regarding the timing, and type of supporting documentation by disbursement method. **Tables 20.2 and 20.3** also at the end of the chapter outline the supporting documentation needed by the Bank from the NAS for transaction-based disbursement and report based disbursement respectively.

### Disbursements: NAC/NACS to intermediaries (eg. Line ministries, NGOs)

#### Box 20.2: Disbursement Documentation

Documentation attached to the claim for disbursement must include at least:

- Physical progress report
- Cash book reconciliation with bank statement and copy of bank statement
- Reconciliation of project Special Account
- Summary of funding to communities
- Summary of intermediary expenditure by disbursement categories
- List of assets purchased by the intermediary and liabilities incurred
- Vouchers for expenditure on individual amounts exceeding \$-- by the intermediary, and
- Summary of projected cash requirements for the next two financial reporting periods.

Prior to project effectiveness NAC/NAS must have evaluated the financial management capacity of proposed intermediary agencies. Similarly, if new intermediaries are identified during project implementation they too should be assessed. Funds should not be transferred to any intermediaries until they have been assessed, agreements have been determined and formally put in place, and appropriate training and briefings provided on the financial management procedures adopted by the MAP.

The disbursement procedures between the NAC/NAS and the intermediaries and communities will largely depend on the procedures adopted between the Bank and NAC/NAS. The key consideration for documentation flow between the intermediaries and NAC/NAS is that it must be consistent with and complement the NAC/NAS reporting procedures and requirements for rapid disbursements.

Submission of reports should be either time bound or tied to a particular level of the project bank account held by the intermediary.

## Disbursements: NAC/NAS and intermediaries to communities

### Introduction

Although a high degree of variation among community projects precludes across the board rules and procedures, some general principles and working procedures apply. In particular, rules and guidelines apply to community projects in the same way that they do for any other project. **However, the application of these rules must be scaled down to the project and to the community's capacity.** The policy requires communities to maintain financial management systems and procedures which are adequate to ensure that they can provide NAC/NAS with accurate, reliable and timely information regarding project resources and expenditures. This is generally a simple record keeping system based on cash in and cash out. The topics noted below clarify procedures associated with key activities at the community level .

### Key procedures and considerations

**Channel selection.** Designers of MAP projects should identify the most appropriate channel to disburse funds in consultation with community members and other stakeholders, ensuring that the chosen channel is compatible with other attributes of good management. Using channels that have been tried and proven successful in the past rather than creating new ones may reduce the risks of funds failing to arrive in the proper place and in a timely fashion, and strengthens the community's capacity to plan and carry out their own programs.

**Channeling funds.** The general rule is that funds should be channeled to the level where the activities are actually carried out. Funds should therefore be transferred to the bank account or cash box of the entity in charge of the implementation (the community, NGO or local government, for example), except in the absence of adequate banking or other security arrangements, or capacity for implementation, when they may be managed by an intermediary agency.

**Financing agreements.** The approval process for community projects includes the need for the community to plan, program, and budget its projects. The forms of the plan and the budgets should be simple and are usually documented in the finance agreement between the beneficiary community and the NAC (or its designated entity). The agreements should contain:

- A comprehensive list of activities, their approximate timing, their estimated costs and sources of financing (including community contributions), and estimated benefits
- A listing of responsibilities for each aspect of the subproject before, during, and after implementation

**Subproject appraisal.** Subproject plans, complete with basic specifications and budget estimates should, in all but extremely exceptional circumstances, be reviewed before they are approved for funding. No matter how simply, the plans should identify the actions needed to complete the project, their approximate cost and timing and expected impact, as well as potential sources of finance and how this will be obtained. This simple procurement planning can help identify which goods, works and services the community can procure for itself, and which will require additional assistance.

**Fiduciary aspects of subproject appraisal.** The sub-project review process should include all pertinent fiduciary aspects. For example, does the team designated to manage the process on behalf of the community include a treasury or bookkeeper? If not, who can be trained quickly to undertake these responsibilities and how will this training be given. Can project funds be located in a secure environment?

**NAC/NAS contribution.** The financing agreement between the NAC/NAS or NGO or other intermediary must specify payment terms to the community. One of two processes can be selected.

**Installment based disbursement.** The financing agreement will specify an advance percentage of the total grant which will depend on the nature of the project. Subsequent installments will depend upon the achievement of certain physical milestones and will not be tied to any specific level of expenditure by the community.

**Progress based disbursement** The financing agreement will specify an advance percentage of the total grant which will depend on the nature of the project. Subsequent payments will be based on financial and progress reports on certain physical milestones. To allow for unforeseen adversity and slow disbursement from the NAC/NAS or intermediary organization, communities should not let their advances fall below 50 percent of the initial grant before they apply for additional advance which should be supported by a copy of the approved sub-project budget.

In the case where funds are to be used for a specific sub-project such as constructing a clinic, the cost should be fully reflected in the proposal and if budget shortfall arise, this can only be met by increasing community contributions or reducing the scope of the sub-project. Where there are budget savings, it is usually good practice to allow the community to use these to finance eligible expenditures under the project without having to undergo a process of formal approval.

**Delinking disbursement of project funds to communities from Reporting of Expenditures and Physical Implementation Progress.** One of the lessons learned in community sub-projects, is the need for availability of cash at all times to ensure smooth implementation of activities. To enable this work, the communities are in turn expected to ensure NAC/NAS receives expenditure reports that include implementation progress not only regularly but also on time. This has not often been possible due to inability of communities to provide formal commercial documentation as evidence that project funds have used efficiently and economically for the intended purposes. This has resulted in many instances of community expenditures being rejected by NAC/NAS. This matter has seriously affected the cash flow available to communities over time, which has brought their activities to a halt, and increased their frustration and apathy. This problem has been fully recognized by donors, and as a result of this, the Bank took the decision to allow the Community Driven Development (CDD) guidelines to be explicitly applied in HIV-AIDS activities at community level. Notification to Bank staff of this decision is included in the relevant annexes.

**Financing agreement topics.** Items which should be addressed in the community financing agreement are located in references.

**Arrangements with an intermediary agency.** In almost every case it is better for the NAC/NAS to establish the basic agreements with the channeling agency, including such aspects as the expected minimum and maximum time needed to transfer funds between each level, payment of fees to the channeling agency, and use of interest earned by the channeling agency on funds held. These arrangements must be transparent and must be adequately explained in the project operational manual.

**Community contributions.** Community contributions reduce overall project costs and are essential to sustain achievements in the long term. Contributions should be established as an element in the project financing plan and in the contract with the community and should be determined during the design stage. The contribution can be in kind which may then be converted to a financial value.

**Tracking community contributions.** Tracking community contributions depends on the overall project design and justification but, in most cases, a rough approximation can be used based on initial proposals or a comparison between the estimated total value of the project and the amount of funding received by the project. The system communities use for tracking contributions will vary and may be based on the type of contribution. Systems for cash contributions should monitor cash received, cash balances, and payments made. Systems for in-kind contributions will vary depending on

whether the contribution is measured by input (e.g. number of days of labor), or output (e.g. length of a trench dug).

**Mitigating risks and internal control.** NAC/NAS should ensure that the risks associated with community projects are mitigated by clear transparent rules and other methods for empowering and training communities to exercise fiduciary control as well as for suitable internal control procedures. The mitigation system should be simple and effective.

Ethiopia has developed an effective mechanism and channel for the disbursement of MAP funds which is described in the box below.

#### **Box 20.3: Experience in Ethiopia**

Disbursement of funds in Ethiopia is achieved: (i) from the NAC/NAS directly to government organizations at federal level and to NGOs and private organizations working in more than one region; (ii) through eleven regional councils to government bureaus, NGOs, private organizations, religious organizations and other groups; and (iii) to about 11,000 kebeles (village units) through 550 woreda (Sub-district AIDS Councils). Woredas receive funds for kebeles from, and account directly to, the NAS.

Kebeles are advanced \$1000 in two tranches for project preparation through their respective woreda which approve kebele projects up to a maximum value of \$2500. Once approved by the woreda a proportion of kebele funds, as determined by a work plan, are transferred from the NAS to the woreda which passes these to the kebele. Replenishment of advances are made by the NAS, via the woreda, after project work has been inspected by the Regional AIDS Secretariat and the kebele has completed a simple form which sets out work completed and the amount of money spent.

## **4. Lessons learned and recommendations**

**One single prescriptive disbursement mechanism does not fit all projects.** Project designers must show flexibility during project preparation and tailor disbursement systems to suit the needs of the program and the capacity of the implementing agencies and communities. This is particularly true for challenging situations such as remote areas and post-conflict countries. Adequate training must also be provided;

**Contracting financial management including disbursement services** has been found to be the most effective way of managing project funds and complying with a donor's fiduciary requirements. However, there is a need for NAC/NAS to provide clear information about MAP and provide guidelines and information on the operations, flow of funds, and reporting requirements to both civil society and stakeholders in the public sector;

**Early evidence suggests funds will flow slowly, or not at all, if the financial management system does not closely monitor implementation progress and be proactive in detecting problems and solving them.**

**Projects that begin quickly after fund approval are more likely to succeed. Mechanisms such as retroactive financing may significantly improve prospects for effective implementation.** MAP should consider reimbursement of eligible expenditures by ex-post examination and reimbursement (including retroactively for expenditures dating back to the date of completion of negotiations) as a measure to provide working capital to NGOs which can scale up quickly.

**Table 20.1 : Timing of Submission of Supporting Documentation By Disbursement Method**

Disbursement method	Transaction-based Disbursement		Report-based Disbursement
Title of supporting document submission	Before each disbursement, with the Withdrawal Application	After each disbursement, with the subsequent Special Account replenishment request	After one or more disbursements, with the subsequent FMR
Reimbursement	√	-	√
Direct payment	√	-	√
Special Account replenishment	-	√	√

**Table 20.2 Documentation Requirements for Transaction Based Disbursements**

Reimbursement	<ol style="list-style-type: none"> <li>i. For contracts above the prior review threshold <ul style="list-style-type: none"> <li>• Summary Sheet &amp; full supporting documentation <ul style="list-style-type: none"> <li>- Invoice from supplier</li> <li>- Evidence of payment to supplier</li> <li>- Proof of shipment of goods or delivery of services</li> </ul> </li> </ul> </li> <li>ii. For contracts below the prior review threshold <ul style="list-style-type: none"> <li>• Statement of Expenditure (supporting documentation to be retained by the NAS for inspection as requested)</li> </ul> </li> </ol>
Direct Payment	<ol style="list-style-type: none"> <li>i. For goods: invoice from the supplier and proof of shipment of goods</li> <li>ii. For services: payment certificate and proof of delivery of services</li> </ol>
Special Account Replenishment	<ol style="list-style-type: none"> <li>i. Special Account Reconciliation statement</li> <li>ii. Special Account bank statement</li> <li>iii. Reimbursement document</li> </ol>

**Table 20.3 Documentation Requirements for Report Based Disbursements**

FMR Includes	<ol style="list-style-type: none"> <li>i. Required minimum FMR content on financial, procurement and physical progress, plus</li> <li>ii. Statements containing Institutional Information <ul style="list-style-type: none"> <li>• Source of supply information <ol style="list-style-type: none"> <li>a. For contracts above the prior review threshold <ul style="list-style-type: none"> <li>- the contractor/consultants name, nationality and zip code</li> <li>- the amount disbursed under each contract</li> </ul> </li> <li>b. For contracts below the prior review threshold <ul style="list-style-type: none"> <li>- aggregate disbursements by country of supply</li> </ul> </li> </ol> </li> <li>• Breakdown of aggregate disbursements by legal disbursement category and disbursement percentage</li> </ul> </li> <li>iii. Special Account reconciliation statement</li> <li>iv. Special Account bank statement</li> <li>v. Forecast of expenditures for the next two FMR reporting periods</li> </ol>
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See Annex 20 (CD-ROM) for further references





# Chapter 21

## General Procurement

### 1. Introduction

**Procurement is a process of purchasing resources** which facilitate implementation of a project activity to achieve a well defined objective. These resources include goods (equipment, material, consumables, including drugs and other medical supplies), civil works (construction/repairs/rehabilitation/extension), services (individual consultants, consulting firms, training, workshops) which are purchased from local and international markets through a transparent and competitive process. National HIV/AIDS Programs (MAP) are unusual compared to more traditional investment projects funded by donors in that they may procure more software<sup>40</sup> than hardware. The procurement procedures help achieving these goals.

Since the MAP invites active participation of the government (including its line ministries), private sector, civil society groups, communities etc., and at various levels of society from the national to the village; the procurement procedures have different scope and applicability (one size doesn't fit all).

In this chapter, key aspects of procurement procedures relevant to the MAP and its key implementing partners are highlighted for the benefit of the project implementation task teams.

References to this chapter provide details and relevant samples from various countries.

### 2. Why a clear understanding of procurement procedures is necessary?

- To get necessary resources such as goods, civil works and consulting services to those who are responsible to deliver project objectives within a time-period;
- To get the right resources, at the right time and at a competitive price by adopting a clear and transparent process to provide equal competitive opportunities for suppliers;
- To enhance accountability by procuring goods, equipment and services through fair, transparent, and competitive processes;
- To avoid serious delays in project implementation and increased costs.

### 3. What is the procurement process?

A procurement process involves clear understanding of (a) what to buy, (b) how to buy, and (c) what legalities are involved in the process. As long as these aspects are clearly known and followed, procurement becomes simpler to manage.

#### Box 21.1: Examples of packages

About 85% of the procurement in health sector development projects financed by the World Bank, is through a national competitive bidding process using government rules rather than through international competitive bidding.

<sup>40</sup>Information, education and communications campaigns, counseling capacity building, community mobilization, and social marketing of condoms etc.



Procurement under NAP is a challenge because it involves procurement management by:

- The NAS/NAC (and its similar structures at the sub-national levels);
- NGO/CBO/FBOs and the private sector;
- CBOs, FBOs, and other civil society organizations;
- Line ministries and government entities (including local government agencies); and
- The Ministry of Health.

## What is Procurement Policy?

Procurement policy is to ensure:

- That resources needed to carry out the project are procured with due attention to economy and efficiency (lower cost, best quality and timely availability);
- Funds are used to pay for resources needed; and
- All suppliers of good, services and civil works have an equal opportunity to compete.

The following<sup>41</sup> key aspects of procurement process are generally common to government and World Bank's procurement procedures :

- Transparency, fairness and fraud prevention is important so that everyone will know that funds are being honestly spent and accounted for;
- Equal opportunity ensures that the suppliers/sellers are provided with equal access to bid;
- Economy and efficiency (value for money) means that goods and services of acceptable quality will be purchased at a reasonable price. This also means that the procurement planning<sup>42</sup> capacity of the beneficiary organizations are satisfactory;
- Effectiveness<sup>43</sup> means that the goods and services will fulfill subproject objectives.
- The ability of the supplier/seller to provide the goods and services has to be documented so that there is assurance that what is promised can be provided.

It is important to know that the funds from MAP are public money and thus accounting for their use is fundamental.

## What to buy?

### By NAC/NAS, line ministries, larger NGOs

These institutions can buy all types of goods, consulting services, and some civil works (see Table 15.1) except military equipment, illicit drugs and large buildings. However, during the project preparation stage (or during its review), an assessment of procurement management capacity is recommended for all involved agencies. Based on this assessment, decisions should be made about which specific items under these categories can be procured by the subject institution(s).

If these institutions lack satisfactory procurement management capacity, then the NAC/NAS should undertake this responsibility, or hire an intermediary (procurement advisory agency or procurement agent) to provide the service.

### Box 21.2: Examples of packages

In Sierra Leone, the Ministry of Health is already implementing an IDA financed project and has a capable procurement unit. Therefore, this ministry can do all its own procurement under the MAP project. Similarly, if other line ministries in a MAP country already have a functional procurement unit, then they can also undertake procurement of items under MAP financing.

<sup>41</sup> Recommendations from the workshop of National HIV/AIDS Program Practitioners held in Nairobi, January 2003.

<sup>42</sup> See section 3.3.4

<sup>43</sup> Efficiency and effectiveness are often ensured through a competitive bidding process in which a bidder has to make available goods and services at the lowest possible price with acceptable quality;

It should be noted that it is not the objective of a MAP to establish new procurement management structures in public and private agencies. Therefore, contracting this responsibility is encouraged as an option to promote efficiency and effectiveness. However, it is NAC/NAS’s responsibility to provide basic training to key implementing partners in sensitizing and training them in essential procurement procedures; this training is usually contracted to specialized firms or qualified NGOs.

**By CBOs, Civil Society Groups etc.**

Under the Local Response component of the MAP, there is enormous flexibility in what communities can purchase. The following general items (given as example<sup>44</sup>) can be purchased by the grant beneficiary groups. During the subproject proposal review, the approval authority (NAC/NAS) should assess the procurement management capacity of the grant applicants and decide whether an applicant can take this responsibility or not. Table 21.1 illustrates what can be purchased by the CBO/FBOs

**Table 21.1**

By the Communities, CSOs and CBOs	By the Intermediaries (groups providing support to the communities)
<ul style="list-style-type: none"> <li>• Renovation or construction work related to a day-care shelter or a room for PLWHA;</li> <li>• Generic drugs like aspirins and lotions;</li> <li>• Seeds/saplings for the harvest and use of indigenous medicinal plants and herbs;</li> <li>• Food rations (or supplements) for PLWHA;</li> <li>• Supplies (e.g., plastic sheets, gloves, mosquito nets);</li> <li>• Hiring of persons/organizations (e.g. local NGOs) to provide technical support for the preparation of community proposals, or in implementing any community based project related activity;</li> <li>• Items related to income generating activities;</li> <li>• Orphan support such as payment of school fees, etc;</li> <li>• Other relevant expenses.</li> </ul>	<ul style="list-style-type: none"> <li>• Items related to capacity building at the community level;</li> <li>• Travel expenses to provide assistance to the communities;</li> <li>• Information, Education and Communications (IEC) materials/equipment and their distribution;</li> <li>• Family life education materials (FLE);</li> <li>• HIV/AIDS prevention promotion (condom distribution and education);</li> <li>• Monitoring and supervision expenses; and</li> <li>• Other relevant expenses.</li> </ul>

<sup>44</sup> All examples are informative since an important element of the MAP approach is to provide maximum flexibility to implementing agencies about program content.

**What are Procurement categories?**

Every item purchased by NAC/NAS, line ministries, NGOs/CBOs/FBOs belongs to a procurement category as presented in Table 21.2.

**Table 21.2. Procurement Categories**

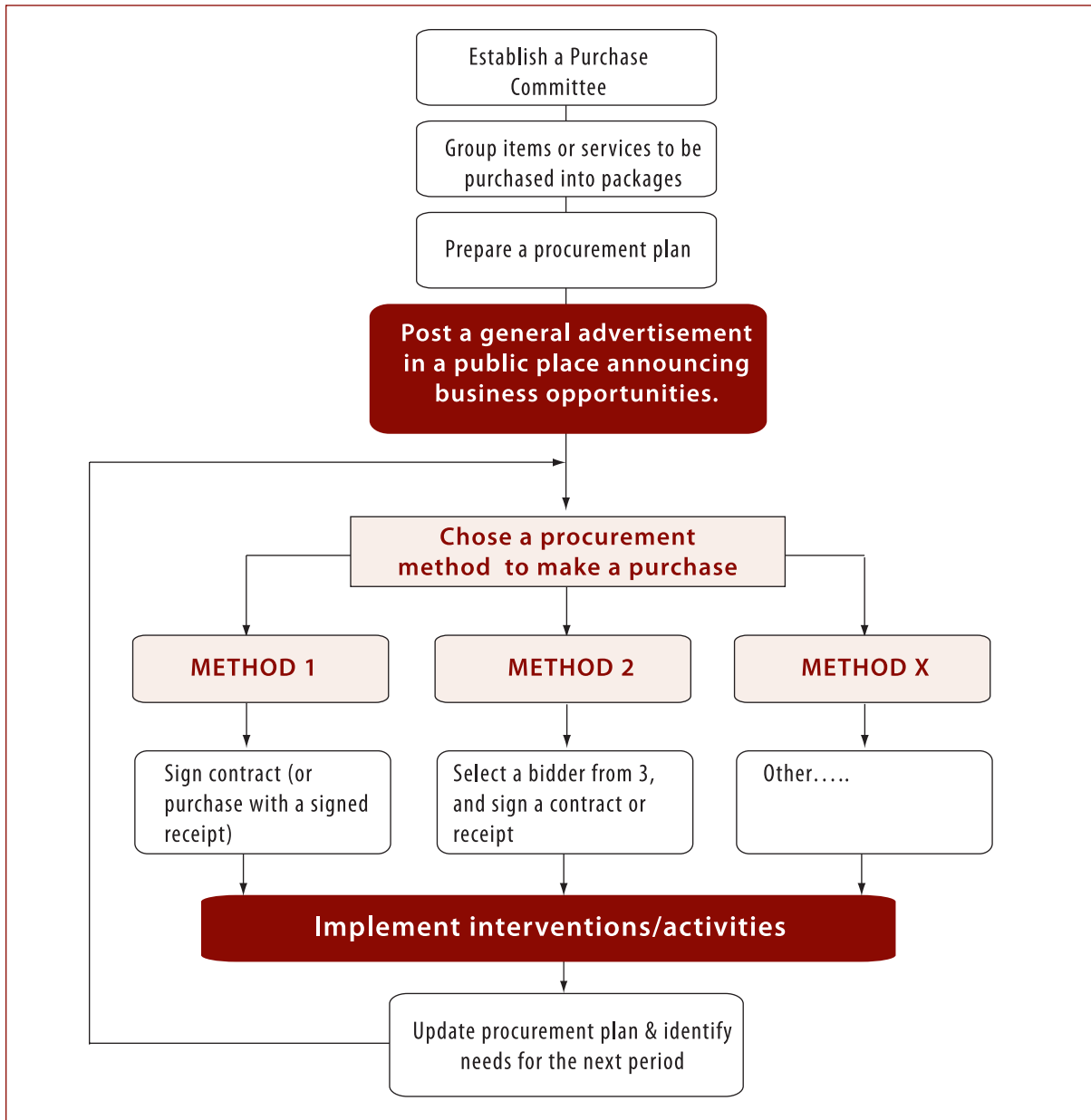
Procurement Categories	Examples
<p><b>1. Goods</b></p>	<ul style="list-style-type: none"> <li>• Equipment (furniture, computer equipment and peripherals, other)</li> <li>• Vehicles (bicycles, motorcycles, sedan cars, 4x4 vehicles, pick-up trucks, vans, ambulances etc)</li> <li>• Printed materials (IEC/BCC materials, books, teaching/learning materials, guidelines etc)</li> <li>• Consumables (office stationery, clinical consumables etc.)</li> <li>• Biomedical equipment (related to HIV testing and storage)</li> <li>• Drugs (for opportunistic infections and ARVs)</li> <li>• HIV test-kits and related supplies</li> <li>• Condoms</li> <li>• Other</li> </ul>
<p><b>2. Consulting Services</b></p>	<ul style="list-style-type: none"> <li>• Individual Consultants (local and foreign: for individual assignments). They are needed for the tasks which do not require a team (individuals can be hired by entities benefiting from the NAP funding, this includes services of accountants, bookkeepers and procurement professionals etc.);</li> <li>• Consulting Firms. Financial management, procurement management, assessments, surveys, studies, research, evaluations, monitoring, supervision, IEC, TV/radio air time, production of IEC materials, systems development and installations e.g. MIS, other NGO or CBOs;</li> <li>• Training. Training of personnel, sensitization, seminars, study tours, workshops, campaigns through seminars). Note that ALL expenses related to conducting a training activity, including the cost of resource persons, consultants, venue, per diems, materials cost is included in the Consulting Services category.</li> </ul>
<p><b>3. Civil Works</b></p>	<ul style="list-style-type: none"> <li>• Major works involve construction of new clinical site or major rehabilitations or extensions (e.g. extension of an existing health care facility to include VCT).</li> <li>• Minor works involve minor repairs of a office building/room, clinics which may include electric re-wiring, re-painting, patch work etc.</li> </ul>
<p><b>4. Community Grants</b></p>	<p>Under this procurement category, NAC/NAS (or its designated government or non-government body) signs a contract with a grant applicant. Or a NGO/CBO signs an agreement with other institutions or individuals to support grant activities like orphan support and income generating activities for PLWHA.</p>

## How to buy?

### Overall procurement process

There are different methods depending on what is being bought and how much would it cost. Figure 21.1 shows the overall procurement process.

Figure 21.1. Overall Procurement Process



**Purchase Committee**

All entities<sup>47</sup> benefiting from the NAP should establish a **Purchase or Procurement Committee** responsible for procurement under the project. The committee should have *at least 3* members having appropriate expertise in technical, financial and management matters; more members can be added. This committee will be responsible for:

- Preparing a procurement plan and updating it regularly;
- Approving what to buy, and when to buy?
- Finalizing technical specifications and terms of references (often very simple) for goods/civil works and consulting services respectively;
- Carrying out the procurement steps defined in the procurement manual prepared by NAC/NAS; and
- Keeping procurement and financial records in proper order for audit purposes.

**Selecting a procurement method**

In general, the choice of a procurement method depends on the *financial value of the resource(s) to be purchased*. For example, the NAC/NAS may decide that all purchases above, say, US\$1000 should use the Local Bidding Method with those below \$1000 using the Quotations based method. Therefore, this US\$1000 becomes the threshold between one procurement method and another. Note that it up to the NAP to set these thresholds.

**(i) Thresholds for NAC/NAS, Line Ministries and NGOs (and similar entities)**

An example of thresholds is given in Table 21.3.

**Table 21.3. Procurement Thresholds**

Financial value of a Package (thresholds)	Procurement Method
Packages of goods costing, for example USD 100,000 or above (the limit is determined during the project preparation)	International Competitive Bidding (ICB)
Packages of goods estimated to cost, for example less than USD 100,000 equivalent up to an aggregate amount (in total project life) of USD 300,000	National Competitive Bidding (NCB)
Procurement for readily available off-the-shelf goods that cannot be grouped together and estimated to cost, for example less than USD 30,000 equivalent up to an aggregate amount (in total project life) of USD 650,000.	Shopping (S)
Condoms may be procured on basis of LIB or, alternatively such goods may also be procured from UN Agencies (e.g. UNICEF, UNFPA, WHO or IAPSO - Inter-Agency Procurement Services Office) provided each such contract does not exceed, for example USD 100,000.	Limited International Bidding (LIB)
Consulting services, usually USD100,000 or more	Quality and Cost Based Selection (QCBS)
Individual Consultants, usually above USD 50,000	Individual Consultant (IC)
Individual Consultants, usually below USD 50,000	Short-list of at least 3 resumes, selection of one and award of contract)

<sup>45</sup> Line ministries, NAS/NAC, NGO/CBO/FBOs

**(ii) Thresholds for CBOs, Civil Society Groups etc.**

An illustrative example is given below in Table 21.4

Threshold: When the value of an item or a package of items is:	Use this method
Above US\$1000	Bidding method (Advertise and select a bidder/seller)
Between US\$500 to US\$999.99	Three quotations method
Below US\$500	Direct purchase or buy off the shelf directly form a seller (Shop around for the best price and keep a receipt)

**(iii) Special procurement considerations for small scale CBOs/FBOs**

In a multi-country workshop on Fiduciary Management in South Africa in July 2003 many participants complained about the difficulty of the “three quotations method” at the community level. It was recognized that many items that are similar throughout the country, for example, school uniforms, textbooks, school stationery (for OVCs), home based care supplies including off-the-shelf medicines and supplies can be purchased using the direct purchase method. NAC/NAS need to identify such items and include them in the grant agreement with the CBO.

**What is included in procurement planning?**

Procurement planning is essentially the scheduling of stages involved in the procurement for goods, works and services, and identifying answers to: What to buy? When to buy? How much/many to buy? From where to buy? and How much to allocate for payments?

**a) Packaging**

To get the best price for goods, services or civil works, similar items should be grouped into packages. For example, registers, pencils, pens, file folders can be grouped into one package and called “stationery”. Procurement packaging has several advantages:

- It offers a better business opportunity to the sellers to supply in bulk;
- Items purchased in packages often result in lower unit cost – therefore cost savings;
- It simplifies actual purchase. All similar items are purchased in one transaction for a period of time. This reduces the hassle involved in buying similar things intermittently; and
- It reduces overhead costs such as frequent advertising, bookkeeping and logistics.

**Box 21.3: Examples of packages**

**Stationery:** Account registers, pencils, pens, file folders and flipcharts.

**Medicines:** Painkillers, Anti-diarrhea, ORS, Vitamins, Antibiotics, Antacids, Cough syrups.

**Home-base care kits:** (a) Towel, soap, waste bag, bathroom scale; (b) Pair of scissors, razor blades, cotton wool, gauze, disposable gloves, specimen bottles, thermometers, bandages. (c) Various food items including rice and beans bags. (d) Soap making items for income generation activities. (e) Other.

Once packaging of the similar items are done, they can be split into different “lots”, spread over a period of time (e.g., the project duration, 12 months, 18 months etc.). “Lots” are to ensure that the goods/services are procured intermittently to ensure their availability for the project duration.

## b) Procurement plan preparation

Once packaging is done, the remaining individual items and the packages should be recorded in the tables presented in *references*<sup>46</sup>. This produces a consolidated list of resources required for the entire project or subproject. For convenience, all goods, services and civil works are grouped under the different tables. Once the tables are completed, a procurement plan is ready.

## c) Funds disbursement vis-à-vis procurement planning

There are two methods NAC/NAS can choose to disburse funds to beneficiary organizations implementing subprojects:

- **Method 1**<sup>47</sup>. Disbursement based on submission of quarterly (or other convenient period) progress report including financial reports. Under this procedure, (i) an organization receives funds for one quarter/period, (ii) implements the activities planned for the quarter, (iii) accounts for the money spent (submits report), (iv) and receives funds for the next quarter or period. The grant recipient keeps the receipts in a safe place for the future audits.
- **Method 2**. Disbursement based on the submission of Statement of Expenditure (SOE). Under this procedure, (i) an organization receives an initial advance (say 40%), (ii) implements activities planned for that advance period, (iii) when the initial advance money expenditure reaches to, say about 50-60%, it accounts for the money spent (submit reports and receipts), and (iv) receives replenishment or the next phase.

### Box 21.4: Fund replenishment period

If an organization finishes its planned activities for a quarter ahead of time, it does not need to wait for the quarter to end (90 days or other period) before it can submit its quarterly report. A report should be immediately sent to NAC/NAS for further funding as soon as planned activities are implemented and the money is accounted for.

Assuming that Method 1 is clearly understood, it is the preferred mechanism for the disbursement of funds for the following reasons:

- An organization can plan for a shorter period (say, quarterly) by focusing on specific and clearly defined activities deliverable in each quarter;
- An organization as well as NAP knows in advance when the reports are expected; therefore cash requirement planning is better for both parties which helps in faster disbursement of funds;
- There is less overhead involved in record keeping and collating financial reports.
- There is no need to attach expenditure receipts with the periodic reports. Receipts are kept with the grant recipient for future audit by NAC/NAS.

Procurement planning should not be affected by the type of disbursement method used. It is basically recommended to facilitate better management and implementation of subproject activities as well as getting value for money. All organization should prepare and regularly update their procurement plans regardless of the method of disbursement used. Where capacity to store goods and suppliers exist, purchase should be made in bulk. 3.3.5. Procurement methods

<sup>46</sup>Note that there are more information required to be entered in reference 21. 2 tables, for example, "Which procurement method will be used?" column. These methods are explained in section 3.3.5

<sup>47</sup> For example, Method 1 is used in Kenya and method 2 is used in Ethiopia and The Gambia.

## Procurement Methods

### (i) Procurement Methods for NAC/NAS, Line Ministries, NGOs (and similar entities)

Detailed steps involved in these procurement methods are provided in Reference 21.1.

**Table 21.5 Procurement Methods**

Procurement Method	What it is?	Applicable to:
GOODS and CIVIL WORKS		
<b>International Competitive Bidding (ICB).</b>	This procedure is used for inviting local, as well as international suppliers/contractors to bid for the goods and services at least 45 days before bid opening. This procedure is usually for the groups of items that are of higher monetary values and/or items that are not locally available. The World Bank's standard bidding documents are mandatory.	<ul style="list-style-type: none"> <li>• NAC/NAS</li> <li>• Line Ministries (which have sufficient procurement capacity)</li> <li>• NGOs (or others which would be involved in international procurement and have sufficient capacity).</li> </ul>
<b>National Competitive Bidding (NCB)</b>	This may be the most efficient and economical way of procuring goods or works given the nature of MAP programs. This procedure is almost the same as a ICB except that the invitation for bids should be published only in the national press at least 35 days before the opening of bids. There are no mandatory standard bidding documents, and the government procedures apply which have been agreed with the World Bank during project preparation.	<ul style="list-style-type: none"> <li>• NAC/NAS</li> <li>• Line Ministries (which have sufficient procurement capacity)</li> <li>• NGOs (or other which have sufficient capacity).</li> </ul>
<b>National Shopping (NS).</b>	This method is used for the procurement of readily available off-the-shelf items that cannot be grouped together into a bigger package of goods. Under this method, items are procured on the basis of quotations from at least 3 eligible suppliers in the country. Requests for such quotations will include a clear description/ specification and the quantity of the goods as well as requirements for delivery time, place for the delivery or services, including any installation requirements as appropriate	<ul style="list-style-type: none"> <li>• NAC/NAS</li> <li>• Public and private entities</li> <li>• NGOs, CBOs, CSOs.</li> </ul> <p><b>Note: Procurement methods for the communities are explained after this table.</b></p>
<b>International Shopping (IS)</b>	This method demands quotations from at least 3 suppliers in 2 different countries. National shopping may be used where the desired goods are ordinarily available from more than one source in a MAP country at competitive prices.	<ul style="list-style-type: none"> <li>• NAC/NAS</li> </ul>
<b>Limited International Bidding (LIB)</b>	This method is essentially ICB by direct invitation without open advertisement. It may be an appropriate method of procurement where (i) the contract values are small, or (ii) there is only a limited number of suppliers, or (iii) other exceptional reasons may justify departure from full ICB procedures. Under LIB, bids from a list of potential suppliers are sought which are broad enough to assure competitive prices, (the list would include all suppliers when there are only a limited number). In all respects other than advertisement and preferences, ICB procedures apply.	<ul style="list-style-type: none"> <li>• NAC/NAS</li> </ul>
<b>Procurement from an UN agency (UN)</b>	There may be situations in which procurement from specialized agencies of the United Nations (UN), acting as suppliers, pursuant to their own procedures, may be the most economical and efficient way of procuring small quantities of off-the-shelf goods, for example condoms.	<ul style="list-style-type: none"> <li>• NAC/NAS</li> <li>• Ministry of Health</li> </ul>



Table 21.5 Procurement Methods *Continued*

Procurement Method	What it is?	Applicable to:
Direct Contracting or Single Source Selection (SSS)	This method is applicable when: (a) an existing contract awarded in accordance with procedures may be extended for additional goods/works of a similar nature; (b) standardization of equipment or spare parts, to be compatible with existing equipment, may justify additional purchases from the original supplier; (c) the required equipment is proprietary and obtainable only from one source; (d) the contractor responsible for a process design requires the purchase of critical items from a particular supplier as a condition of a performance guarantee; (e) in exceptional cases, as in response to natural disasters.	<ul style="list-style-type: none"> <li>• NAC/NAS</li> </ul>
CONSULTANTS	(firms and individuals)	
Least Cost Selection (LC)	This method is more appropriate for the selection of consultants for assignments of a standard or routine nature (audits, engineering design of noncomplex works, and so forth) where well-established practices and standards exist, and in which the contract amount is small (amount is determined during project preparation).	<ul style="list-style-type: none"> <li>• NAC/NAS</li> <li>• Line Ministries (which have sufficient procurement capacity)</li> <li>• NGOs (or others who have sufficient capacity).</li> </ul>
Quality and Cost Based Selection (QCBS)	QCBS is used to procure services of individuals or firms when the quality of the output is of the first concern, and then the cost. QCBS uses a competitive process among short-listed firms that takes into account the quality of the proposal and the cost of the services in the selection of the successful bidder. Cost as a factor of selection is used judiciously. The relative weight to be given to the quality and cost is determined for each case depending on the nature of the assignment.	<ul style="list-style-type: none"> <li>• NAC/NAS</li> <li>• Line Ministries (which have sufficient procurement capacity)</li> <li>• NGOs (or other who have sufficient capacity).</li> </ul>
Selection Based on Consultant's Qualification (SBCQ)	This method may be used for very small assignments for which the need for preparing and evaluating competitive proposals is not justified.	<ul style="list-style-type: none"> <li>• NAC/NAS</li> <li>• Line Ministries (which have sufficient procurement capacity)</li> <li>• NGOs (or other who have sufficient capacity).</li> </ul>
Single Source Selection (SSS)	Single-source selection may be appropriate only if it presents a clear advantage over competition: (a) for tasks that represent a natural continuation of previous work carried out by the firm/consultant, (b) where a rapid selection is essential (for example, in an emergency operation), (c) for very small <sup>48</sup> assignments, or (d) when only one firm is qualified or has experience of exceptional worth for the assignment.	<ul style="list-style-type: none"> <li>• NAC/NAS</li> <li>• Line Ministries (which have sufficient procurement capacity)</li> <li>• NGOs (or other who have sufficient capacity).</li> </ul>

**(ii) Procurement Methods for CBOs, Civil Society Groups etc.**

There are three methods for CBOs, Local NGOs and similar organizations, but two of the three methods are most commonly used. All three methods are described below:

**a) Direct purchase method**

In the Direct Purchase method, the CBO/LNGO Procurement Committee approaches a supplier/seller or service provider familiar to the community, to provide the goods or consultancy services. After negotiations, the item/service is purchased (or a contract is signed, if needed) for the negotiated price.

**Box 21.5 Examples of Direct Purchasing.**

- Any good or consultancy service that is below the threshold defined by NAS in a table similar to Table 15.3 in this manual.
- If above the threshold and there is only one qualified supplier or service provider in the community.
- If above the threshold and there is an immediate/urgent need to hire the services of a specialist or to buy some supplies.

<sup>48</sup>Amount is determined during project preparation

This method is applied for all purchases that are below the financial threshold defined by the NAS (for example see Table 21.4).

However, there may be instances when some good/service is required but its estimated financial value is above the threshold for direct purchase method. This situation may arise due to the following:

- The competitive methods<sup>49</sup> cannot be used due to exceptional reason(s) like distance, availability of goods/services, higher overhead etc;
- Only one supplier or service provider has the qualifications or has experience of exceptional worth to carry out the assignment; or
- The assignment represents a natural or direct continuation of a previous contract awarded competitively, and the performance of the supplier or service provider has been satisfactory; or
- A quick selection of the supplier is essential, for example, in emergencies.

The decision on the use of this method's is made on the basis of strong and convincing justifications, and where it offers clear advantages over the competition. It is recommended that these justifications be provided in the subproject proposal.

But when a direct purchase has to be made above the prescribed threshold for the method, the **advantages** include: immediate availability of resources in a shorter period of time and facilitation in dealing with emergency situations or to encounter sudden unforeseen needs. And the **disadvantages** include: lack of transparency and risk of lack of providing opportunities to other prospect suppliers/service providers who would have provided a better service at a lower cost.

### b) Quotations<sup>50</sup> based method

This method involves collection of at least three quotations (or proforma invoices) from different suppliers/service providers. Essentially, the CBO/NGO purchase committee determines what to buy; then at least three quotations are collected and the least expensive which is acceptable in quality is selected and purchased

The **advantages** of this method include: getting value for money through competition, transparency and ease in accountability/audit, and business opportunity for the suppliers/service providers. The **disadvantages** include effort and time involved in obtaining three quotations (which may not be available in one place), overhead in terms of selection of a supplier and record keeping.

### c) Local bidding method

This method is more elaborate than the quotations based purchase method. It is applicable to higher value purchases and requires more procurement experience. This method requires advertisement of goods and services needed, giving some time to all prospect bidders to quote their prices in sealed envelopes and to submit their bids, opening of the bids in the presence of all bidders, comparing the services offered and costs, selection of a successful bidder and award or signing of a formal contract.

Since this method is not currently in general use by the CBO/NGOs in implementing their HIV/AIDS activities, the whole method is described in **References** with relevant forms and formats.

However, as CBO/NGOs start scaling up their activities and start receiving more financial support from the NAP and procuring more goods and services; it is likely that they will need to apply this method.

<sup>49</sup> Quotations based or local bidding methods explained later.

<sup>50</sup> Also known as Proforma-Invoice based purchase or Local Shopping method.

## What are the possible contract relationships in a MAP project?

### Contract types

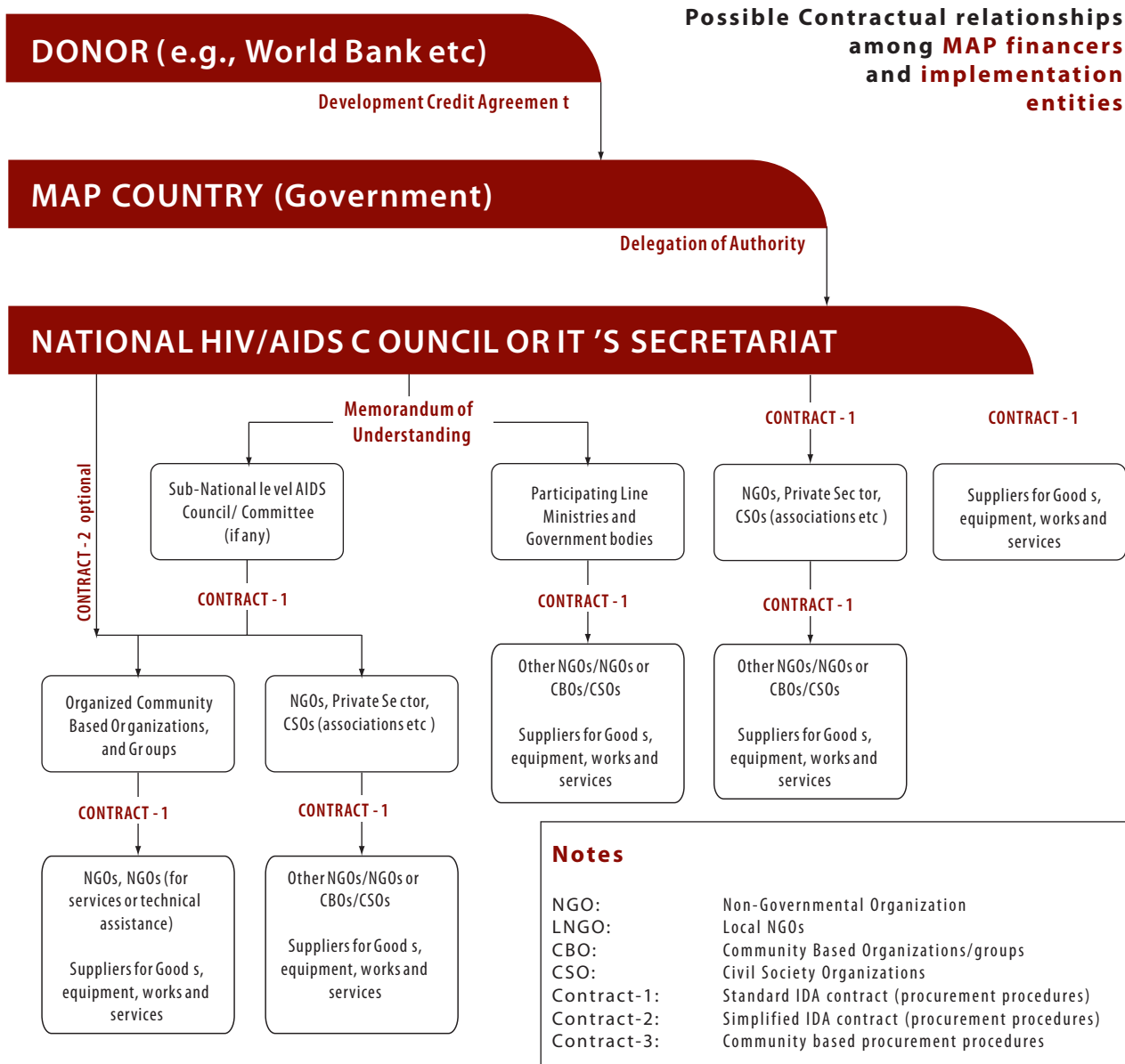
Obtaining the funding for procurement depends upon contractual agreements between the key funding and implementation entities. The following figure represents various contractual relationships among the MAP partners. The types of contracts shown in Figure 21.2 are:

**Contract type 1: Standard contracts;**

**Contract type 2: Simplified contracts (or simplified procurement procedures);**

**Contract type 3: Contracts related to community based procurement.**

Figure 21.2. Contract Relationship



- The legal agreement signed between the donor (e.g., World Bank) and an authorized Government institution (like Ministry of Finance) is known as a **Development Credit/Grant Agreement** or a **DCA/DGA**. The contents of the DCA/DGA should be well known to the NAC/NAS project implementation team..
- The Government (or its DCA/DGA signing authority) **delegates** project coordination responsibility to a national institution. In the MAP's case, it is the National HIV/AIDS Council and/or its Secretariat (NAC/NAS).
- NAC/NAS signs a **Memorandum of Understanding** or an **MOU** (a sample is presented in **Reference 15.3**) with other government bodies which includes participating line Ministries (or departments of state), Sub-National level government bodies like District Government, Commissioner's Office or District HIV/AIDS Committees; Social Fund management, Central Statistical Offices, Universities and other institutions. The MOU contains an agreement to deliver well-defined outputs/objectives under a agreed funding arrangement(s);
- NAC/NAS may sign **Contract agreements** with (a) NGOs (local or international) or similar entities, (b) private sector, associations and other organized entities; (c) CBOs/Communities (if needed); (d) suppliers/contractors. Also see the chapter on Contracting. Clear outputs to be delivered through these contracts should be described in (a) **Terms of Reference** (for services including technical assistance, training, and mobilization) and/or, (b) **Technical Specifications** (for goods and civil works);
- NAC/NAS can also directly sign **contracts** with Community Based Organizations (or groups) if they are organized and have the basic capacity to manage finances and deliver the outputs. This may become necessary where there is no other intermediary body existing (for example, district HIV/AIDS committee or a government structure – this may be a case in a post-conflict situation). Another situation may be when there is an intermediary body, but which is not ready to undertake MAP associated responsibilities and a CBO is capable to undertake a subproject;
- In an ideal situation, it should be a community group that should sign a contract (if needed) with a local NGO for technical assistance;
- The Community Based Organization, or Civil Society Organization (organized groups) can further sign **contract agreements** with suppliers/contractors per simplified procedures for the community based procurement. Generally, procurement of goods and services at the community levels involves very simple procedures based on transparency and simple record keeping.

### Service Contracts or Output-based contracts

A service contract is an agreement between MAP and NGO/CBO which has satisfactory fiduciary capacity to deliver well defined deliverables/outputs within an agreed cost and time period. In such a case, the NGO/CBO can apply its own fiduciary process and keeps the essential record of all expenses.

The NGO/CBO is held responsible for providing evidence that the outputs/outcomes of the contract are delivered in the quality and substance agreed with the NAC/NAS in the grant agreement/contract.

#### Box 21.6

The Ghana HIV/AIDS program signs service/output-based contracts with CBO/FBOs on agreed outputs for smaller grants. The recipient CBO/FBOs receive 100% advance payment to deliver the outputs. Ghana AIDS Commission monitors the delivery of outputs through its M&E officers located at the District level.

Ghana will be the first country implementing the MAP project ahead of planned project closing date.

#### 4. Lessons learned and recommendations

- **Contracting major operational functions significantly improves efficiency.** Some of the key contracting may include the following:
  - a) Financial management (accounting, disbursement and reporting, etc)
  - b) Procurement management (procurement management, procurement advisory services or both)
  - c) Community and Civil Society Initiatives component management, involving receiving subproject proposals, evaluation, approval, implementation, supervision and disbursement (all or selected operations)
  - d) IEC material development and nation-wide campaign activities
  - e) Community mobilization (to identify their needs, prepare proposals and manage funds)
  - f) Social marketing of condoms
  - g) Capacity development of core MAP focal points
  - h) Grant subproject receiving and technical evaluation
  - i) Sensitization of staff of participating line ministries and preparation of programs for ministry staff and clients
  - j) Financial Audit (mandatory)
  - k) Procurement Audit
  - l) Equipment maintenance
  - m) Vehicles maintenance
  
- **World Bank's procurement rules/procedures are extensive and flexible** but are not always understood; therefore the operations manual should clarify them in detail. These rules/procedures should be clear to stakeholders in advance of implementation, and field-tested, to manage expectations. Implementing agencies at all levels need sensitization and training in procurement funded by NAC;
- **Availability of local expertise in procurement planning and management is usually insufficient** given that the MAP provides funds to a large number of independent entities in the public and private sectors and to civil society. Alternatives should be identified early in the project including hiring international procurement specialists/firms for short- or longer-term assignments. However, local capacity in procurement planning and management should be built by training at all levels, and hiring of short-term consultants/firms at the start-up stage;
- **The procurement procedures should not be burdensome,** especially for small amounts (community-grants). Make the rules fit the implementation agency rather than vice versa.
- **Major bottleneck occurs when a responsible entity (or person) of a project component does not properly prepare terms of reference** (for consulting services) or technical specifications (for goods and works), or the procurement unit of the NAC/NAS doesn't prepare bidding documents correctly.
- **The situation is similar with NGOs** (or organized bodies) which are delivering services under a contract with NAC/NAS and are also engaged in subcontracting. These NGOs (or similar entities), should clearly understand the project's procurement rules, procedures and formats.
- **Procurement planning** task should be completed early in project preparation and reviewed regularly to avoid delays. The procurement plan should be an integral part of annual work plans;

- **The International Competitive Bidding (ICB) process** is time consuming (averaging 5-7 months). However, in practice, the ICB procedure is not a frequently used method in MAP projects; the bulk of ICB goods are usually acquired during the first 12-18 months of a MAP project;
- **Simplified and speedy procedures** can be proposed for time-sensitive goods and services, especially drugs;
- **The project operations manual should clearly highlight various contractual agreements** between NAS and (a) government institutions, (b) with suppliers/contractors; and provide samples of the contract/agreement documents for goods and services;
- **Procurement of condoms** and associated social marketing as well as some medical procurement invite special attention.
- **In certain cases, the government's review bodies (such as the Treasury, Ministry of Finance, Central Tender Boards etc.) may take unusually long in reviewing the bidding documents.** It should be noted that about 85% of procurement in the health sector development projects financed by the World Bank has been through National Competitive Bidding processes, applying the government rules agreed during project preparation.
- **Procurement audit** (and monitoring) should be conducted for major NGO/CBO/CSO subprojects, and spot checks of community based subprojects;
- **A separate, simple procurement procedures manual should be prepared for the CBOs,** or community based groups. The manual should be clear on responsibilities and reporting; and should be distributed in local languages;
- **Procurement thresholds** for the community-based subprojects should be increased for community groups that have gained demonstrated experience.
- **Procurement results should be publicized** to share information and increase transparency;
- **Service (or output-based) contracts** for smaller grants to the CBOs/FBOs/NGOs are easier to manage. However, the NAC/NAS should have sufficient capacity for the monitoring of delivered outputs;
- **A simple list of purchase items** that are similar throughout the country can be produced by the NAP. These items need not require 3 quotations or a bidding process by the community groups.



See Annex 21 (CD-ROM) for further references and sub-manual on Generic Procurement Manual for CBOs and Local NGOs





# Chapter 22

## Procurement of HIV/AIDS Medicines and Supplies

*(Executive Summary of Battling HIV/AIDS: A Decision Maker's Guide to the Procurement of Medicines and Related Supplies)*

### 1. Introduction<sup>51</sup>

Antiretroviral therapy (ART) has radically changed the outlook for people who have access to it. Living longer, healthier lives, they can become productive and able to care for them selves. ART is not a cure, but it diminishes the viral load and thus reduces damage to the immune system. It also reduces the statistical risk of passing on the virus through whatever route — blood, breast milk, and sexual or other bodily fluids.

Despite some dramatic reductions in the last three years, the costs associated with antiretroviral drugs (ARVs) and other medicines for HIV-related problems are still very high and may remain so. Skilled negotiation and lobbying on behalf of—and by — people with HIV, especially by the Clinton Foundation, has already had a dramatic effect in reducing prices. But even when full advantage is taken of the lowest possible prices on the global market, the annual total cost of antiretroviral therapy is still more than the national budget for health care in some countries.

Much higher costs will be incurred in countries that cannot get low - cost supplies for patent or other market reasons. Costs will also be higher if drug resistance develops and more expensive alternative medicines have to be used. So for many countries, assistance from the World Bank, the Global Fund for AIDS, TB and Malaria, and other key donors will be essential to make the public health promises of antiretroviral therapy a reality, at least in the foreseeable future.

Planners and decision makers must have a clear understanding of the importance of treatment in tackling HIV and ensure that specific services and facilities required for treatment be included in the scaling up effort:

- HIV counseling, testing, and follow-up services for adherence to treatment and psychosocial support.
- Capacity for appropriate management of HIV and opportunistic infections.
- Laboratory services for monitoring treatment.
- Continuous supply of ARVs, other medicines for HIV-related illness, supplies for laboratory tests and preventive precautions.
- Reliable regulatory mechanisms to ensure the quality of treatment, while protecting the individual's right to treatment.

Experience has shown that the cost of the ARV drugs is only part of the antiretroviral therapy and that other costs, such as additional drugs, biological monitoring, personnel, equipment, testing, etc. are usually as expensive if not more expensive than the ARVs. Ensuring that the comprehensive support package is funded is essential to the success of antiretroviral therapy.

Procurement is only one link in this large network of factors affecting the HIV epidemic. Yet it is clearly vital. Successful treatment depends on continuous, reliable supplies of the necessary medicines and related commodities. Without sustained access to antiretrovirals, the challenge of treatment cannot be met—and the ravages of the epidemic will continue.

<sup>51</sup> This chapter is a summary of *Battling HIV/AIDS: A Decision Maker's Guide to the Procurement of Medicines and Related Supplies* published by the World Bank and available on the World Bank Procurement website at: <http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/PROCUREMENT/0,,pagePK:84271~theSitePK:84266,00.html>



## 2. Estimating resource requirements

Estimating the financial and resource requirements of an antiretroviral treatment program is a key step in assessing its feasibility and sustainability. Resources for direct treatment are not the only obstacle to introducing and scaling up an antiretroviral program. The lack of physical and human health infrastructure and the inadequacy of systems to distribute essential medicines affect the availability of drugs and financial feasibility. In all cases, the finances for such a program would have to include expenditure on both capacity building (if it is not adequate) and the purchase of drugs and related medical supplies and services — but in varying proportions, depending on skill sets, income levels, epidemic proportions, and local needs in each situation.

## 3. Dealing with patents

Many HIV/AIDS medicines and laboratory products are relatively new, still protected by patents granted to the originators, usually within countries where the originator has, or expects to have, a significant market. But the patent situation varies widely across countries, affected by such international agreements as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). That makes it important for staff responsible for project implementation to assimilate the information in this guide. Early clarification of the intellectual property rights situation (and of registration requirements and import regulations) will prevent frustration, wasted time and money, and possible litigation.

As a consequence of the Doha Declaration on the TRIPS Agreement and Public Health, adopted by Members of the World Trade Organization in November 2001, “least developed” countries are authorized to forgo the enforcement of patents on pharmaceutical products at least until January 1, 2016. When a least developed country government and its procurement authority take advantage of this maximum flexibility, HIV/AIDS medicines may be imported (or locally produced) without concern about whether patents on these medicines have been granted within the country.

Developing countries that are not considered “least developed” have the option to override existing patents by issuing a compulsory licensing or government use authorization. A patent is a government grant that permits its holder to exclude third parties from the market for a product, such as an HIV/AIDS-related medicine. A “compulsory license” is an authorization by the government to itself or to a third party to use the patent without the permission of the patent holder. When the government is authorizing its own use, this is also called a “government use” authorization or license, which is a form of compulsory license.

Important HIV/AIDS medicines or supplies are covered by one or more patents in many countries. If the procurement authority wishes to procure a bioequivalent medicine (a generic version) from a party other than the patent holder or its authorized distributor, including by importing the medicine, it may need to authorize procurement under a compulsory license. The TRIPS Agreement, in Article 31, authorizes every government to grant compulsory licenses.

## 4. Managing the supply cycle for better outcomes

The medicines supply cycle comprises all elements required for the establishment and continuity of supplies for health delivery, including medicines and related commodities. It includes four key stages with a central requirement for good management support, an understanding of the policy and legal frameworks for the supply cycle, and an appreciation that medicines are special commodities that have constraints concerning quality assurance, storage, and use.

Two key elements of the cycle are selection and procurement. But to get good results, it is clear that these must not happen in isolation. All elements of the cycle must function well, and the broader context must be understood so that a holistic and realistic approach can be taken to achieve the best possible results in each setting.

In many countries, a national drug policy will set out approaches for achieving these priorities within the national context. Such policy is also likely to include setting requirements for registration of drugs and limiting who may prescribe, dispense, or sell them. National HIV/AIDS treatment policies must also be consulted, since these set out guidelines for approving HIV treatment regimens and who is entitled to prescribe them.

**Some key policy or legal issues that affect procurement include:**

- Intellectual property (patent) legislation of medicines—the national patent situation will directly affect what products can be procured from which suppliers and what scope there will be for negotiation on prices. Refer to Figure 2.3 of the *Battling HIV/AIDS: A Decision Maker’s Guide to the Procurement of Medicines and Related Supplies* in references (CD-ROM)
- Health rights and access to HIV-related treatment—when limited supplies, particularly of ARVs, are available, eligibility criteria will be applied to selection of which members of the population qualify for treatment. This will affect product selection and quantification and may change as scaling up proceeds.
- Security issues—antiretroviral medicines for HIV treatment are high in value and thus vulnerable to theft and diversion to illegal markets—or to individuals who are not priority recipients of HIV treatment programs. So, planning the supply cycle will have to incorporate effective security measures and a legal framework that allows for sanctions against theft or diversion.

## 5. Deciding who does what

An assessment should be made at an early stage to find out who is already carrying out the tasks related to the supply cycle and to test whether funding is needed for the setting up of new systems and personnel, the use of existing ones, or a combination of both. A preliminary mapping exercise could be used to identify different systems and personnel relevant to the HIV procurements. The strengths and weaknesses of each one should be examined, estimating their willingness and capacity. A period of rapid growth will be a feature of most HIV treatment programs during scaling up. This may strain the capacities and funding of all those who have a part in treatment delivery. It may thus have unforeseen effects on their ability to provide cooperation as programs develop.

When it is clear who can do what for HIV procurement in a specific country, a further assessment of the proposed procurement systems should be carried out. An assessment of the initial situation should also lead to the setting up of monitoring and evaluation criteria and tools for the ongoing performance monitoring of procurement. Performance indicators and monitoring procedures, responsibilities, and finance will be expected.

## 6. How drugs should be selected for HIV-related treatment

Public health criteria for selecting antiretroviral drugs and drugs for opportunistic infections focus on drugs of the greatest importance to satisfy the health needs of the majority of the population of HIV-positive people:

- The selection of drugs should be carried out by a multidisciplinary group, including representatives of the national AIDS committee or council and the national drug formulary committee, together with an HIV specialist doctor, an HIV specialist nurse, a pharmacist with knowledge of available HIV-related medicines, and a procurement specialist. Additional members may be added on an ad hoc basis.
- Drugs should be identified in any printed material by their generic name, or international nonproprietary name. But abbreviated chemical names and brand names will also be used when appropriate.
- Drug selection should be based on predetermined criteria, as recommended by the World Health Organization (WHO) or any existing guidelines of the national drug or AIDS programs.

## 7. Deciding on quantities

It is important to realize that in situations where the HIV/AIDS epidemic or responses to it are expanding, careful judgment will be necessary to arrive at the correct quantities of each commodity needed for procurement and deciding how much to buy. Underestimates will deprive people of necessary treatments or tests. Overestimates may waste resources if limited shelf life products expire unused, especially as treatment protocols and diagnostic preferences change.

Three methods can be used for quantification:

- The usage (consumption) method that relies on past use (consumption) records to estimate future need.
- The adjusted usage (adjusted consumption) method that uses data from other facilities, regions, or countries, adjusted or extrapolated to the specific situation on the basis of population coverage or service level.
- The patient morbidity-standard treatment method that estimates the need for specific drugs, based on the expected number of attendances, the prevalence or incidence of diseases, and standard treatment guidelines for the health problems that are to be treated.

## 8. Assessing capacity

In many countries the implementing agencies might lack the capacity to forecast, procure, store, and distribute antiretroviral medicines and other related medical supplies of the HIV/AIDS care package. It is therefore essential to examine the procurement capacity of the central medical stores for this category of specialized drugs and supplies before deciding on the project's procurement strategy and plan.

If the central medical store is deficient and poorly managed, a third alternative must be sought (such as employing a specialized procurement agency or a UN agency). This agency can be required, as part of its contractual obligations, to include a training, capacity building, and technology transfer component intended to strengthen the capacity of the central medical store.

## 9. Commodities that support the HIV/AIDS program

The HIV/AIDS commodities package is more complex than other products and supplies managed in the public sector:

- A functioning lab infrastructure is essential to support service delivery (equipment, supplies, and human resources).
- The supply chain must be agile and responsive in changing situations, delivering products before they expire or are diverted.
- Service delivery and provider, client, and community education are in the early stages of development, unlike more established health programs.
- A set of comprehensive, interdependent services needs to be provided.
- Decentralizing interventions to the community adds to complexity of planning, coordination, distribution, and management—because the technical skills for managing these products may be lacking or insufficient.

The HIV/AIDS care package comprises three main product categories: multisource or generic products, limited-source products, and single-source products. Each category corresponds to a distinct procurement strategy:

- Multisource products are pharmaceutically equivalent products that may or may not be therapeutically equivalent, available from different manufacturers. They are well established, normally off patent, and not restricted by continuing intellectual property agreements or other exclusive market arrangements. They are generally available from a wide range of producers, have published pharmacopoeial quality standards, and available reference standards for quality-control testing.

- Limited-source products are pharmaceutically equivalent products available from a limited number of manufacturers. Newer, they are products usually protected by patents or market-exclusivity arrangements in some countries. Pharmacopoeial quality standards and publicly available reference standards for quality control testing may not yet be available.
- Single-source products are generally under patent with no licensing agreements that allow other firms to manufacture the drugs. Single-source availability may be due to patents, marketing exclusivity, technical challenges of production, or a lack of economic incentives for production by other manufacturers. Pharmacopoeial quality standards and publicly available reference standards for quality-control testing might not be publicly available.

## 10. Choosing procurement methods

The market situation of each product, the nature of the medicines and medical supplies, and the critical dates for delivery—all are major factors determining the choice of procurement method. Choices are restricted by the characteristics of medicines and supplies of the HIV/AIDS care package. As already noted, the majority of antiretrovirals and some other HIV-related drugs are either single-source or limited-source products. Other drugs and commodities for opportunistic infections or for basic or palliative care may be multisource but effectively restricted to limited sources in many settings. So, international (or national) competitive bidding without prequalification typically cannot be the preferred method of procurement. Instead, limited international bidding, direct contracting, or shopping may be the most appropriate. The key is to understand what situations are suitable for each of them. Refer to Figure 5.2 of the *Battling HIV/AIDS: A Decision Maker's Guide to the Procurement of Medicines and Related Supplies* in references (CD-ROM)

## 11. Pricing

The price of medications can be a significant barrier to HIV/AIDS treatment, especially for antiretroviral therapy, a chronic treatment that requires the daily intake of a combination of pharmaceutical compounds. The coverage of health insurance in developing countries is often limited. And when drugs are purchased out-of-pocket, the price of antiretrovirals can make a vital difference for poor people's ability to afford treatment. Even the lowest available prices are unaffordable for most patients in the developing world, where about 3 billion people live on less than \$2 a day. Many HIV-infected patients rely

### Box 22.1: Clinton Foundation Agreements for Lower-Priced Drugs and Diagnostics

In April 2004, the Global Fund, UNICEF and the World Bank joined the Clinton Foundation HIV/AIDS Initiative (CHAI) in announcing agreements that will make it possible for developing countries to purchase WHO-approved high-quality AIDS medicines and diagnostics at the lowest available prices, in many cases for more than 50% less expensive than is currently available. These prices have been negotiated by CHAI with five manufacturers of ARVs and five manufacturers of HIV/AIDS diagnostic tests and are available in 16 countries in the Caribbean and Africa where the Clinton Foundation has existing partnerships. The April agreements will pave the way for all World Bank and Global Fund recipients to access the reduced pricing. While all suppliers may not be able to service every country, due to limited distribution networks, drug registrations and other factors, there will be suppliers in every country that joins the program. Countries interested in accessing the program should contact the Clinton HIV/AIDS Initiative before contacting suppliers directly. Contact information for the Clinton HIV/AIDS Initiative is as follows:

**Clinton HIV/AIDS Initiative**  
**225 Water Street**  
**Quincy, MA 02169 USA**

**Tel:** +1 617 774 0110  
**Fax:** +1 617 774 0220  
**Email:** [procurement@hivaidsinitiative.org](mailto:procurement@hivaidsinitiative.org)  
**Website:** [www.clintonpresidentialcenter.com/AIDS\\_overview.html](http://www.clintonpresidentialcenter.com/AIDS_overview.html)

on the subsidized or free provision of antiretroviral treatment by the public sector. For resource-constrained governments in poor countries, the purchase price for the pharmaceutical compounds directly affects the number of patients that can be treated. And lower prices leave more room for investments in complementary health infrastructure needed to make antiretroviral treatment effective.

## 12. Assessing the economic impact of antiretroviral therapy

A primary challenge facing policymakers is estimating the benefits of antiretroviral therapy. In the short term simple models of resource estimation can be used to determine the immediate budgetary implications of antiretroviral therapy. Given the enormous resources required for administering antiretroviral therapy, it is essential to ensure effectiveness and safety.

Treatments must be proven to work not only in “ideal” clinical trials, with closely monitored patients in a hospital setting, but also in a context likely if the program is scaled up. A realistic study should consider compliance and adherence to treatment under alternative strategies, such as DOT (directly observed therapy) strategies, to account for the potential misuse of drugs.

Economic constraints—the fact that other health considerations need to be addressed—call for a critical appraisal of the pros and cons of all technically feasible interventions, and put a premium on rational resource allocation so that health needs can be addressed holistically.

## 13. Lessons learned and recommendations for MAP projects.

- Antiretroviral therapy requires a complete package of support including funding and making available in a timely fashion ARVs and other drugs, testing equipment, monitoring, personnel, logistics, etc.
- Donors must be willing to finance local costs and operating expenses in order to scale up and maintain antiretroviral therapy for large numbers of people.
- Since the procurement of ARVs is both complicated and infrequent, many countries would benefit from contracting this capacity from specialized agencies and agents.
- An early clarification of Intellectual Property Rights situation (and of registration requirements and import regulations) will prevent frustration, wasted time and money, and possible litigation.
- An assessment should be made at an early stage to find out who is already carrying out the tasks related to the supply cycle and to test whether funding is needed for the setting up of new systems and personnel, the use of existing ones, or a combination of both.



# PART V



Monitoring & Evaluation & Supervision





# Chapter 23

## Monitoring and Evaluation

### 1. Introduction

M&E is summarized in this chapter and covered in depth in the *UNAIDS/World Bank National AIDS Councils (NAC) Monitoring And Evaluation (M&E) Operational Manual*. Readers are referred to this manual in the References for detailed M&E guidelines. The MAP does not seek to promote its own M&E system, but to support one overall national M&E system under which MAP supported components fall. The M&E chapter focuses on “program” M&E rather than surveillance of the epidemic and does not include needs assessments, which are discussed under social assessment.

### 2. Why is program M&E important?

Sound M&E is vital in order to:

- **Determine Program Effectiveness:** Since a prime objective of the MAP is to scale up existing programs without the traditional a priori technical assessment of program effectiveness and efficiency, early and comprehensive results from M&E are critical to determine which programs are successful and should be expanded further and which are less successful and should be stopped or provided with capacity building;
- **Identify and Address Problems:** Detect and address problems so that continuous project redesign and improvement become standard operating procedures;
- **Show Impact:** Provide early evidence of program impact;
- **Gather Evidence of Activities and Results:** Gather evidence of activities and results to communicate to those infected and affected by HIV/AIDS in transparent and objective ways the effort being made to improve prevention, care and treatment, and mitigation programs; and
- **Strengthen Fiduciary Responsibility and Accountability:** M&E is a core part of the fiduciary architecture of financial management, procurement and M&E.
- **Show Transparency:** M&E enables grant-making bodies to establish transparent grant-making and supervision procedures, as well as transparent systems for communicating progress, thus enhancing public confidence in their overall transparency.

### 3. What is M&E?

#### Distinguishing Between M&E

Confusion between M&E is common. There is a simple distinction between monitoring and evaluation that may be helpful. Monitoring is the routine, daily assessment of ongoing activities and progress. In contrast, evaluation is the episodic assessment of overall achievements. Monitoring asks: “*What are we doing?*” Evaluation asks: “*What have we achieved?*” or “*What impact have we had?*”



## M&E Framework

Effective M&E is based on a clear, logical pathway of results, in which results at one level are expected to lead to results at the next level, leading to the achievement of the overall goal.

The major levels are:

- Inputs
- Outputs
- Outcomes
- Impacts

These levels are described in the table below:

**Table 23.1**

Level	Description
<b>Inputs</b>	Inputs are simply the people, training, equipment, facilities and resources that we put into a project, in order to achieve outputs
<b>Outputs</b>	Outputs are the activities or services we deliver, including AIDS prevention, care, support and mitigation services, in order to achieve outcomes. The processes associated with service delivery are very important. The key processes include quality, unit costs, access and coverage
<b>Outcomes</b>	Through quality, economical, accessible, widespread services, key outcomes should occur. Outcomes are changes in behaviors or skills, especially safer HIV prevention practices and increased ability to cope with and ameliorate the consequences of AIDS
<b>Impacts</b>	These outcomes are intended to lead to major health impacts. Impacts refer to measurable health impacts, particularly reduced STI/HIV transmission

Results at the final impact tier may take several years to observe, so it is important to set realistic targets at the impact level.

## M&E Components

**M&E consists of the following major components:**

**Table 23.2**

Component	Description
<b>Overall system</b>	A governing flowchart, which describes precisely how data are collected and flow into an overall data base, which integrates the data specified in the flowchart
<b>Surveillance</b>	National biological and behavioral and social surveillance of STI/HIV/AIDS/TB sexual behavior and social rates and trends
<b>Research</b>	Essential prevalence, incidence and evaluation research, to complement national surveillance
<b>Financial monitoring</b>	National financial management monitoring, of NAC, the public sector and civil society's utilization of resources
<b>Program activity monitoring</b>	National program activity monitoring of NAC's contracting and grant-making and the relevance, quantity and quality of public sector and civil society services delivered

These components are related to framework and levels presented above. The overall system encompasses all levels. Surveillance and research provide data primarily at the outcome and impact levels. Financial and program activity monitoring provide data primarily at the input and output levels.

## M&E Strengths

The strengths of each M&E component vary widely:

- **Overall System:** Few countries have an overall M&E system, with a governing flowchart and integrated data base;
- **Surveillance:** Surveillance is well developed in many countries, particularly in countries with mature AIDS epidemics and is well supported by international agencies, which have prepared sound guidelines;
- **Research:** Surveillance should be complemented by essential research. NACs have a strategic role in collating, interpreting and disseminating research findings;
- **Financial Monitoring:** Financial management monitoring is well supported; and
- **Program Activity Monitoring:** Program activity monitoring is the least developed and requires the greatest emphasis. It is addressed partly through operations manuals, but significant challenges remain. NACs will assume a major grant-making role, supporting hundreds of AIDS prevention, care and mitigation activities. They lack essential systems and procedures. Program activity monitoring should be combined with financial management monitoring and contracted to a single independent entity.

### Box 23.1: Role of Global HIV/AIDS Program M&E Team

While UNAIDS is responsible for coordination of global level M&E, the UNAIDS sponsors are funding the World Bank to improve the coordination of country level M&E. In partnership with UNAIDS and other major development partners, the World Bank Global HIV/AIDS Program M&E Team is supporting the coordination of country level M&E capacity building, and providing and brokering M&E technical assistance. The Global HIV/AIDS Program M&E Team have three major foci:

#### Country Support Team Assistance to National M&E Systems

The Global HIV/AIDS Program (GHAP) has recruited and trained a Country Support Team (CST), comprising 10 international M&E specialists to provide support to national M&E systems. Each M&E specialist supports a portfolio of 2-4 countries. Their major task is to promote the recruitment of national, in-country, M&E specialists in their portfolio of countries and thereafter to closely support the national, in-country M&E specialists, through regular field support visits, e-mail and telephone contact. By February, 2004, GHAP's CST had made 85 M&E field support visits to 31 countries/projects, providing approximately 10,000 person hours of intensive M&E field support. The CST assisted NACs to develop M&E frameworks, prepare M&E operational plans, calculate M&E operational budgets, recruit M&E staff and consultants, strengthen bio-and behavioral surveillance, research and program monitoring and establish functioning M&E systems.

#### Rapid Results Initiative

In Eritrea, the Global HIV/AIDS Program M&E Team piloted a highly successful Rapid Results Initiative, which uses M&E as a motivational and performance enhancement tool. Assisted by expert coaches, managers set major goals they wish to accomplish within 100 days, then analyze the steps to achieve these goals. In Eritrea, managers used the Rapid Results approach to eliminate needlestick infections in hospitals and to greatly expand VCT coverage. It is a highly empowering and motivational approach, which has attracted great interest in Eritrea and elsewhere.

#### Community and Program Learning

In Uganda and Ethiopia, the Global HIV/AIDS Program M&E Team is using Lot Quality Assurance Sampling (LQAS) to assess program coverage quality, coverage and effectiveness. LQAS is a sophisticated sampling technique that allows inferences to be robustly drawn from extremely small samples. It is highly structured and supported by training manuals and field tools, developed and refined over many years. It is also highly participatory, engaging service delivery managers and personnel in the assessment of services. It provides data which enables managers to identify under-performing areas and to make rapid tactical changes to improve performance. LQAS has been extremely successful, for example, in empowering Ugandans to assess the performance of the Community HIV/AIDS Initiative (CHAI) and to make major tactical changes to enhance its performance.

In summary, the most developed components are: surveillance (especially biological surveillance); research; and financial monitoring. The least developed components are: the overall M&E system; and program monitoring. These components thus require particular attention.

## Putting M&E into practice

The following operational procedures are proposed to put M&E into practice at the implementation level.

- **Establish Incentives:** International agencies should establish incentives for functional M&E systems, by making them a prerequisite for future support. This is a major tenet, for example, of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).
- **Coordination:** NACs should clarify their coordination role and increase their capacity to coordinate not implement M&E;
- **Contracting out:** NACs should adapt a framework in which they contract out implementation of M&E, to specialized entities. Thus, (i) surveillance, (ii) research, (iii) financial monitoring and program monitoring should be contracted to a range of public, private and civil society entities;
- **Program Approval:** It is vital to build implementing agency M&E into the activity approval process;
- **Participatory Process:** NACs and stakeholders should engage in an intensive participatory process, to build ownership and buy-in, particularly for the overall M&E system and program monitoring;
- **Agreeing Targets:** Each implementing partner should agree its key targets with NACs, using a simple Planning, Monitoring and Evaluation Form;
- **Monthly Reporting:** Each implementing partner should report results monthly using a simple Planning, Monitoring and Evaluation Form;
- **Verification:** These results should be checked and verified at appropriate intervals by the specialized monitoring entity;
- **Assessing Progress:** The specialized entity should assess each implementing partners' progress towards targets every six months and rate their progress using a simple Planning, Monitoring and Evaluation Form;
- **Reporting to NACs:** The specialized entity should collate, analyze and submit to NACs six monthly summary reports, using a simple Progress Report Form;
- **Stakeholder Review Meetings:** NACs and key stakeholders should meet regularly to review M&E reports, to ensure utilization of data by all stakeholders, to identify key lessons learned and to make strategic recommendations and decisions; and
- **Updating Manuals and Procedures:** NACs and key stakeholders should update their M&E manuals and procedures based on lessons learned.

## 4. Lessons learned and recommendations

The following key M&E lessons have been learned:

- **Incentives:** Unless there are the strongest incentives to establish functioning M&E systems, they are unlikely to be established. Evidence suggests that “performance based management systems”, such as those required by GFATM, tend to develop M&E systems more reliably and rapidly. The 2004 MAP mid-term review funded by the World Bank recommended that the establishment of a fully functional M&E system during existing MAP grants be a prerequisite for future MAP support.

**Box 23.2: Example of implementing agency M&E**

The Project Support Group (PSG) is a regional organization with its headquarters in South Africa and HIV/AIDS prevention and care programs in eight Southern African countries. Since its origins in 1986, PSG has emphasized sound monitoring, including program activity monitoring, using very simple, practical systems.

This investment in program monitoring enables PSG to demonstrate the scope of services supported to partners and beneficiaries. For example, from 1990 to mid-2001, PSG partner prevention projects recruited and trained 2,467 community educators, conducted thousands of community behavior change communication meetings, reached hundreds of thousands of people, including repeat attendees and distributed more than 140 million condoms. Over the same period, PSG partner care projects recruited 5,400 care trainers, enrolled more than 400,000 HIV/AIDS patients and conducted tens of thousands of care visits. PSG are also able to link their services to important outcomes, including reduced STI transmission and improved coping and quality of life.

The key lesson learned is that by rigorously tracking prevention and care services provided, PSG is able to demonstrate to partners and communities that they are a significant national and regional provider of essential prevention and care services and to use this data to attract increased support from international, government and private sector funders. NGOs who do not track their services miss a vital opportunity to demonstrate how important their services are and to influence policy and funding decisions.

- **Simplicity:** M&E systems should be as simple as possible. Most programs collect far more data than they use. The more complex a M&E system, the more likely it is to fail;
- **Underestimating capacity building needs:** Experience shows that the amount of technical advice and national capacity building required to develop functioning M&E systems have been underestimated. Thus, these components have been under-funded.
- **Funding:** NACs lack comprehensive, long-term funding for all major M&E components, including local costs and incremental operating costs. The World Bank, through MAP credits, may provide comprehensive, long-term M&E funding where grant funding is unavailable. The World Bank recommends that up to 10% of MAP credits be used for the investment and operating costs of a long-term M&E system;
- **Dedicated M&E budget line:** Evidence shows that, unless M&E is protected through a non-fungible component or budget line, M&E allocations tended to be absorbed into general salaries and administrative expenses, leaving no resources for M&E. It is vital to establish a separate, protected, M&E component or budget line.
- **Beyond indicators:** To date, international focus has been on indicator sets and less on the systems required to collect the indicators. MAP programs should move beyond indicator sets, to focus on recurrent M&E systems.
- **Operational plan and budget:** There are many M&E strategy papers. However, one must move beyond M&E strategy papers to develop detailed M&E operational plans, with clear responsibilities, milestones and a fully costed M&E budget. This is a major milestone in the evolution of functioning M&E systems.
- **Stakeholder buy-in:** No matter how sound a M&E system may be, it will fail without widespread stakeholder “buy-in.” Thus, a large-scale, participatory process is essential to build ownership and “buy-in” from the start;
- **Implementing agency capacity:** Implementing agencies often lack appropriate M&E systems and require technical and financial support from the program activity monitoring agency to effectively utilize the proposed M&E system;
- **M&E systems should be operational before activities begin:** M&E must be built into the design of a program and operational when grant-making begins, not added later. It is harder and less effective to “retrofit” M&E after grant-making is underway;

- **Contracting:** Program activity monitoring should usually be combined with financial monitoring and contracted to a single, independent entity, for economy and finance-program cross-verification;
- **Standardization:** M&E systems must include a standardized core. If each implementing partner uses different systems or tools, data cannot be coherently summarized. The need for a standardized core does not preclude individual implementing partners from collecting additional, situation-specific M&E data<sup>52</sup>;
- **M&E for management:** Many MAPs have tended to focus on longer term goals, which are not helpful for immediate program management needs. One should establish shorter-term milestones, in which one specifies and measures what will be achieved after three months, six months, one year and so on. This makes M&E more central to decision making.
- **Internal assessment and external verification:** M&E requires both internal self-assessment and external verification. Thus, implementing partners should collect their own internal data and an external entity should verify the completeness and accuracy of the data. Supervisory visits should be based on the analysis of internal self-assessment and externally verified primary data.
- **Use M&E to learn lessons:** A major lesson is to design mechanisms to use M&E lessons to improve future programming.



See Annex 23 (CD-ROM) for further references and sub-manual on National AIDS Councils Monitoring and Evaluation Operations Manual

<sup>52</sup> The sponsors of UNAIDS, including the World Bank, have endorsed the notion of “one agreed country level monitoring and evaluation system.”



# Chapter 24

## Social Assessment

### 1. Why is social assessment important?

HIV/AIDS is a social disease that can only be fought with deep-rooted changes in values, attitudes and behavior.

Understanding the fundamental social and behavioral causes and consequences of HIV/AIDS and providing a mechanism for stakeholder consultation are the primary objectives of social assessment under the MAP. Each country's social system and values are distinct. Mapping these systems and their underlying values is essential to understand the characteristics of the epidemic and formulate sustainable strategies to combat it. Using social assessment to stimulate stakeholder discussion about the impact of HIV/AIDS and how to combat the epidemic is another outcome of the social assessment process.

Social assessment is a major tool for intervention development, guiding the design of HIV/AIDS prevention, care, treatment, support and mitigation interventions.

### 2. What is needed to uncover the social dimensions of HIV/AIDS?

**Social assessment (SA) is a:**

- Tool to uncover the social causes and impacts associated with investment projects, including those related to HIV/AIDS;
- Process through which project implementation agencies understand how a country's or a community's social, cultural, political and institutional context influences social outcomes;
- Means to enhance equity in the distribution of benefits to affected communities and to strengthen social inclusion; and
- Mechanism through which (a) social cohesion can be rebuilt in HIV/AIDS-affected communities, (b) accountability and transparency can be promoted in the delivery of MAP-funded services, and (c) the poor and affected groups can be empowered to join the fight against the epidemic.

**In MAP programs, social assessment is particularly valuable in**

- Providing a framework for dialogue with affected communities on development priorities and in building coalitions for change;
- Identifying opportunities, constraints, impacts and risks associated with the MAP program's implementation, and mechanisms to mobilize stakeholders to fight the epidemic;
- Complementing economic and institutional analysis to deepen the understanding of the adverse impacts on the poor and defining poverty reduction measures.

A good social assessment will describe the social “mosaic, analyze formal and informal institutions, identify key interest groups and define strategies for empowering individuals and groups to join the war against HIV/AIDS. It will also incorporate continuous stock-taking to ensure the social outcomes and impacts are achieved. (See Chapter 23 M&E).

## 2 There are four “pillars” of social assessment

**The First Pillar—Analysis of Social Diversity and Gender.** Social environments are by their very nature complex and diverse, and understanding them requires a multi-disciplinary approach and a mix of qualitative and quantitative tools. Baseline data are essential, given the experimental nature of the MAP program. SA aims to capture the different needs, expectations and potential contributions of all stakeholders: men and women, ethnic, religious and cultural groups and others. The real value-added of SA derives from its concrete and situation specific focus. The more specific the understanding of the social factors of the epidemic in each county, region and community, the higher the chances of success in identifying appropriate prevention, mitigation and care programs.

Gender issues are at the heart of the epidemic and consequently at the center of social analysis. Women and girls are most vulnerable. Only in Africa is the incidence of HIV/AIDS higher among women than among men. Culturally defined concepts of masculinity, dominance, sexual rights and responsibilities, marital and pre-marital relationships and care need to be understood at the outset and continuously in the design and refinement of strategies. Empowering women through the legal framework on women’s rights and adjusting roles and power relationships within the family and society are part of the strategy to equalize women’s access to information and services, and mobilizing men and boys to take greater responsibility for their actions. See sub-manual on “Integration of Gender Issues in selected HIV/AIDS Projects in the Africa Region”

Orphans are among the most important groups for attention under the MAP. The design and implementation of projects depends on the understanding of the social arrangements that have had to develop to accommodate them. (See Chapter 23—Mitigation).

Generally, understanding social diversity in detail will help in the design of appropriate information, education and communications strategies, and in building strategies for empowering women and young people to take responsibility for their own protection.

**The Second Pillar—Stakeholder Analysis and Participation.** Stakeholders are groups of people connected by formal or informal ties who are affected by MAP programs. Understanding their perspectives and the likely impact of the project on them is essential for good project design. Good analysis requires time, patience, resources and a great deal of local knowledge and expertise, and is often best handled community by community.

Participation is critical to successful development and implementation of projects (See Chapter 2 - Lessons of Experience), but it is often the most difficult challenge of the SA process. Stakeholders, especially the vulnerable and excluded groups, need to be involved in project design and execution. A participation action plan is needed (but often omitted from SA), based on the level of awareness among different groups and their attitudes toward alternative methods of prevention, care and treatment and mitigation.

Community driven development programs and social funds are an effective mechanism for stimulating participation, but may not be feasible for HIV/AIDS interventions where awareness of the problem may be limited. (See Chapter 11-Communities).

**The Third Pillar - Social Institutions, Rules and Behaviors.** In addition to understanding the complex social diversity and stakeholder attitudes and relationships, SA undertakes an evaluation of the formal and informal institutions and networks that will be involved in project implementation, including their capacity, structure, rules, and incentives.

The institutional analysis focuses on the feasibility of proposed targeting measures, the sustainability of the proposed participation arrangements and the interaction between beneficiaries and implementing institutions. It identifies “social capital” that can be used to build development activities and to mobilize local stakeholders.

The poor and vulnerable groups for whom the HIV/AIDS program is intended often face difficulty in accessing project resources. There are many reasons, formal and informal—attitudes, customs, laws, practices, and information. It is important for the social analysis to assess the basis for exclusion and evaluate the potential success of new interventions and institutional arrangements, including a review of legislation, business practices and community norms, and to suggest ways to create a more favorable environment and to mobilize community support for the poor and other affected populations.

**The Fourth Pillar - Social Impact Monitoring (SIM).** The monitoring of social impacts of HIV/AIDS projects is essential for assessing the effectiveness of project initiatives and drawing lessons of experience. The indicators to be tracked should include patterns of inclusion/exclusion, human rights, empowerment and social risk mitigation. The objective is to ensure that all persons have access to HIV/AIDS information, prevention, care and social support. Empowerment means that all stakeholders become “AIDS-competent” and act to protect themselves and care for the afflicted.

**Box 24.1: Some key indicators for social impact monitoring would include:**

- Awareness and accurate knowledge by social group of HIV/AIDS transmission and prevention methods and evolution of the public perception about people living with AIDS
- Participation rate by social group in voluntary testing and counseling activities (VCT) and reports of desirable behavior change
- Non-discriminatory access of all groups to VCT, treatment for STDs and home care as well as non-discriminatory behavior by service providers
- Percent of community members participating in care for HIV/AIDS victims and their families
- Increased NGO/CBO skills in designing and managing effective interventions, including financial management aspects
- Restoration of economic welfare for persons and families living with AIDS
- Continued enrollment of orphans in school
- Reduction in AIDS-related violence (by or towards AIDS victims)

### 3. Lessons learned and recommendations

- **Social Assessment is perhaps the weakest link in the design of MAP Projects.** An adequate understanding of the fundamental characteristics of stakeholders and client groups, including their values, beliefs, behaviors, etc. is essential for the design and implementation of both national strategies and specific projects. This is often difficult at the project design stage given the time and resources required and the great diversity of environments involved. The need for a good SA is particularly acute at the community level. Agencies executing community programs, both public and private organizations, should be required to present a social assessment to qualify for support.



- **“Communities of interest” are not well studied.** Baseline information is often inadequate about such groups as migrant workers, refugees, prisoners, sex workers, the military, homosexuals and drug users who all have different social characteristics. This constrains program effectiveness and the effort to scale up.
- **Informal social organizations are key to HIV/AIDS programs.** Social assessments often do not have an adequate appreciation of informal social organizations and networks that can combat HIV/AIDS infection, such as traditional faith healers.
- **Continuous social assessment, or social impact monitoring, is vital to understanding program performance.** As indicated in Chapter 16-M&E- tracking implementation performance and impact is especially important in MAP projects, that are by their nature experimental. Social impact monitoring is a particularly important and often neglected aspect of M&E, given the basis for the epidemic and the means to combat it both lie in social behaviors. Strategies and activities need to be adjusted and re-adjusted regularly to ensure they reach the right people in an effective manner. Social indicators need to be a part of the regular M&E monitoring process.
- **Social assessment capacity building is essential.** The integration of social concerns in HIV/AIDS projects can only be achieved by building local capacity for SA, both in implementation agencies (public and private) and at the non-technical level for the NACs and NASSs.
- **Public agencies, especially sector ministries,** should do a social assessment of their own work force and their clients. Public sector ministries should assess the social factors within their own organizations and in their client audiences prior to undertaking MAP-financed activities as a means of establishing relevant programs with strong support and encouraging stakeholder participation.



See Annex 24 (CD-ROM) for further references



# Chapter 25

## Program Supervision

### 1. Why is supervision<sup>53</sup> important?

The objective of the MAP approach is to scale up existing programs and build capacity to empower stakeholders from the village to the national level, in every sector, and in the public sector as well as civil society to join the war against the epidemic. Countries have a responsibility to supervise the implementation of MAP programs to ensure that:

- Program activities are carried out as planned;
- Programs that are successful are scaled up further and those that are not are provided with capacity building or halted;
- Funds are spent efficiently, effectively and transparently;
- Both beneficiaries and financing agencies are provided with timely and complete information on the appropriate disposition of funding.

### 2. What is good supervision?

Good supervision includes the review of the results of monitoring and evaluation, visits to observe development of activities in the field, and discussions with different stakeholders about progress in program implementation and necessary improvements in program plans. There is considerable experience from both the public and private sectors on what are the core elements of good supervision, as suggested in Box 25.1.

#### Box 25.1: What is Good Supervision?

- Performance can only be judged by a mix of quantitative and qualitative program/ financial/social monitoring that is evaluated with the participation of both stakeholders and independent experts.
- Operational and management performance is assessed realistically based on developments on the ground rather than on hopes and promises.
- Problems are identified quickly and reported candidly, always keeping in mind the program's objectives.
- Program redesign is a normal part of continuous consultations and feedback among key stakeholders, especially implementing and oversight agencies.
- Emerging issues are addressed proactively, incorporating global good practices adapted to country circumstances.
- Fiduciary aspects are monitored closely to ensure compliance with agreed standards.
- In view of the importance of behavior change to win the war against HIV/AIDS, all supervision should emphasize both stakeholder participation and social impact monitoring.

<sup>53</sup> This chapter deals with management and operational supervision of HIV/AIDS programs and not the technical supervision of HIV/AIDS prevention, care and support, and mitigation activities which is extensively covered elsewhere.

**Program supervision in a MAP country goes on at various levels and use a variety of mechanisms:**

- Implementing agencies in the public sector and in civil society are responsible for first-line supervision, especially with regard to the basic fiduciary requirements of: (i) financial management and reporting; (ii) procurement of goods and services; (iii) disbursement of funds to beneficiaries; and (iv) monitoring and initial evaluation of program activities. Supervision arrangements of implementing agencies should be embodied in the funding arrangements between NACs and the agencies;
- The NACs, through their secretariats, are responsible for overall operational and program supervision, a responsibility which may be delegated and/or contracted out, in part or in whole, to specialized agencies. Supervision includes the monitoring of various phases of program activities: (i) financial reporting and oversight of program inputs, often on a monthly basis; (ii) reviews with implementing agencies, often on a monthly basis for trouble shooting and on a quarterly basis to review performance<sup>54</sup>; and (iii) on an annual basis for formal program review with donors and beneficiary agencies and for fund-raising. (It may be appropriate to plan semi-annual reviews at the beginning of a project). The annual reviews are described in box 25.2.

**Box 25.2: Annual Program Reviews****Annual reviews by the key internal and external stakeholders can:**

- Review progress towards implementing a country's HIV/AIDS strategic plan;
- Develop an effective mechanism for collaboration and distribution of funding within national goals;
- Assess the performance of MAP activities during the previous 12 months, focusing on improving performance and issues such as equity, coverage and inclusion; and
- Agree on the main priorities and the annual work program for the forth-coming 12 months, including the assurance of sufficient national and international funding
- Reduce the administrative burden on a MAP country of numerous un-coordinated donor supervision throughout the year.

- Donors will also supervise MAP programs to which they provide funding and technical expertise both as part of their fiduciary responsibility and of their development objective of providing the benefits of knowledge management and good practices from around the world.
- NASs need to use a variety of mechanisms to assess implementing agencies both in the public sector and civil society, including field investigations. In Ghana, for example, the central authority has employed field investigators to visit selected beneficiary organizations to verify that NGO's and CBOs, which have received subproject grants are implementing them for the intended purposes.

<sup>54</sup> Annex 20.1 has a sample NGO progress report from Kenya. Annex 20.2 has a regional progress report from Ethiopia. Annex 20.3 has a progress report at the local level. Annex 20.4 has a community subproject reporting form from Uganda.

Table 25.1

<b>Field Supervision Checklist</b>	
<b>Preparations</b>	
<ol style="list-style-type: none"> <li>1. Identify supervision activities. For example, meetings, field visits, stakeholders consultation etc.</li> <li>2. Ensure all relevant background documents and reports are available. For example, project document, annual work plan, M&amp;E reports, financial statements, and previous supervision reports.</li> <li>3. Identify objectives, methodology, type and timing of supervision.</li> <li>4. Inform the entities/persons<sup>55</sup> who would be part of the supervision activity and agree on the objectives and supervision dates.</li> </ol>	
<b>Terms of Reference (TOR)</b>	
<ol style="list-style-type: none"> <li>5. Clearly spell out the objectives of the supervision including inputs and outputs of the project activities as well as outcomes and impact.</li> <li>6. Identify if there have been any changes in the grant recipient's commitments since the project inception.</li> <li>7. Get management's approval and share<sup>56</sup>.</li> </ol>	
<b>Team composition</b>	
<ol style="list-style-type: none"> <li>8. Identify team members based on what focus areas would be covered in the supervision.</li> <li>9. Ensure appropriate continuity of the team.</li> <li>10. Have subject matter specialist in the teams.</li> <li>11. Share TOR and the team composition with key stakeholders involved in the supervision.</li> <li>12. Incorporate their feedback including adjustments in the logistics.</li> <li>13. Ensure supervision activities and their timings are suitable for all.</li> </ol>	
<b>Conducting supervision</b>	
<ol style="list-style-type: none"> <li>14. All members of the team should review the project documents before conducting the supervision.</li> <li>15. Follow up on the daily progress with each team member and record issues, findings, recommendations and decisions agreed with the counterparts – constantly strategize the next steps.</li> <li>16. Conduct meetings with the counterpart team/individuals and stakeholders (including grant beneficiaries) focusing on the issues and implementation bottlenecks.</li> <li>17. Conduct field visits. Cover at least 1-5 subproject sites if possible. Record beneficiary's views, problems and observations.</li> <li>18. Convene team meeting with the counterparts and discuss the findings and recommendations (within the existing capacity of implementing agency).</li> <li>19. Incorporate counterpart's views.</li> </ol>	
<b>Report preparation</b>	
<ol style="list-style-type: none"> <li>20. Address issues listed in the TOR and other issues identified during the supervision.</li> <li>21. Spell out specific suggestions and adequate guidance to the grant recipient of the actions to be taken, by whom and by when.</li> <li>22. Assess how much the project/subproject has so far achieved its targets set out at the time project started.</li> <li>23. Get counterpart's observations and suggestions.</li> <li>24. Conduct a team meeting with the grant recipient team and reach agreements on the report findings, recommendation and achievement targets.</li> <li>25. Finalize and share the report with the stakeholders.</li> </ol>	

<sup>55</sup> Entities/persons may include NAC/NAS, MOH, participating line ministries, donors, NGO/CBOs; depending on who would be joining the supervision.

<sup>56</sup> Share with the head of the project management entity. For example, if the World Bank team is supervising, the Task Team Leader of the Bank should share with the head of the project management unit (or NAS).

### 3. Lessons learned and recommendations

While it is early to have a large number of definitive lessons about supervision, there are recommendations in several areas.

**Supervision responsibility and mechanisms should be built into project design.** Agreeing on what should be funded, through which mechanisms, and with what geographic spread assumes that these activities can be supervised to ensure efficiency and effectiveness. Having an appropriate monitoring and evaluation system in place is the essential requirement of supervision.

**NACs should contract specialized supervision and delegate certain areas of supervision as appropriate.**

NAC/NAS will not want to hire in the extensive skills needed for supervision of most program activities or for the fiduciary elements of all program activities. NAC/NAS should therefore contract specialized agencies for financial management and disbursements, procurement oversight, and most elements of monitoring and evaluation. Epidemic monitoring is almost always delegated to Ministries of Health and other specialized institutions. The NAC/NAS remain responsible for the general oversight of project implementation and the performance of the contracting agents.

**Key stakeholders and beneficiaries should be involved in program supervision.** While the broad membership of the NACs themselves ensure that many stakeholders will be involved in MAP program oversight, it is often useful to have more specialized stakeholder representatives; although not always easier to implement, this may be achieved by the creation of a civil society oversight body with a small but distinct budget and staff.

**Annual reviews are essential means of involving all stakeholders in performance review and budget preparation and funding<sup>57</sup>.** These reviews are best done on the basis of a preparation mission that puts together reports for consideration by stakeholders and decision-makers. Quarterly reviews can be done as needed on specific topics.

**External Partners can play an important role in program supervision, especially in bringing in examples of good practices from around the world.**

The role of technical resource networks, the UN AIDS Theme Group, and of individual donors is discussed in the chapter on external partners. However, evidence so far, mostly from the World Bank, suggests that donors may substantially underestimate the supervision required to fulfill their fiduciary requirements and the quality enhancement that may result from more intensive interaction and provision of international good practices. The specific recommendations on Bank supervision coming out of the joint UNAIDS/World Bank progress reviews of the MAP and of the Bank's performance include:

- Supervision strategies should be prepared by Bank team teams as part of project preparation that provide a similar level of support during supervision as during project preparation;
- The complexity of MAP programs need larger Bank supervision teams covering more fiduciary and thematic areas than usual, requiring more than twice the average level of Bank administrative budget resources;
- The senior Bank official in country should be responsible for the Bank's contribution to external partnership;

<sup>57</sup> Annual reviews can be supplemental to quarterly reviews on more urgent operational issues and on special topics and on the regular supervision of implementing agency performance

- While day-to-day supervision assistance may be helpful, the strategic focus and overall review of formal supervision missions is essential, especially to enhance international good practice;
- Joint supervision missions among external partners, especially through the joint annual reviews, promote coordination and collaboration while reducing the burden on MAP countries of multiple, uncoordinated donor missions.





# PART VI



Program Themes







# Chapter 26

## Prevention

### 1. Introduction

This chapter (Prevention), Chapter 27 (Care and Support), and Chapter 28 (Mitigation) are *bookmarks*, a reminder that material on these subjects will be added and revised regularly. National HIV/AIDS programs focus on *what* is to be done to promote prevention, care and support, and mitigation of HIV/AIDS. These chapters of the GOM will provide useful lessons of experience on how efforts in these thematic areas may best be addressed, whether these programs involve mother-to-child transmission or assisting hard-to-reach communities. *It is a living document*, to be replenished and expanded as lessons emerge. The following list of prevention themes is meant to be illustrative not exhaustive.

#### Mass communications

- What are the major elements of mass communication campaigns?
- What examples of good practice are there in mass communications?
- What resources materials exist for mass communications?
- What organizations in different countries offer training in mass communications?
- What are the major costs and sources of support for mass communications?
- What are the major lessons of implementation experience in mass communications?

#### Interpersonal communications

- What are the major elements of interpersonal communication campaigns?
- What examples of good practice are there in interpersonal communications?
- What resources materials exist for interpersonal communications?
- What organizations in different countries offer training in interpersonal communications?
- What are the major costs and sources of support for interpersonal communications?
- What are the major lessons of implementation experience in interpersonal communications?

#### Condom distribution and promotion

- What are the major elements of condom distribution and promotion?
- What examples of good practice are there in condom distribution and promotion?
- What resources materials exist for condom distribution and promotion?
- What organizations in different countries offer training in condom distribution and promotion?
- What are the major costs and sources of support for condom distribution and promotion?
- What are the major lessons of implementation experience in condom distribution and promotion?

**STI care**

- What are the major elements of STI care?
- What examples of good practice are there in STI care?
- What resources materials exist for STI care?
- What organizations in different countries offer training in STI care?
- What are the major costs and sources of support for STI care?
- What are the major lessons of implementation experience in STI care?

**HIV counseling and testing**

- What are the major elements of HIV counseling and testing?
- What examples of good practice are there in HIV counseling and testing?
- What resources materials exist for HIV counseling and testing?
- What organizations in different countries offer training in HIV counseling and testing?
- What are the major costs and sources of support for HIV counseling and testing?
- What are the major lessons of implementation experience in HIV counseling and testing?

**Blood and injection safety**

- What are the major elements of blood and injection safety?
- What examples of good practice are there in blood and injection safety?
- What resources materials exist for blood and injection safety?
- What organizations in different countries offer training in blood and injection safety?
- What are the major costs and sources of support for blood and injection safety?
- What are the major lessons of implementation experience in blood and injection safety?

**Prevention of mother to child transmission (PMTCT)**

- What are the major elements of PMTCT?
- What examples of good practice are there in PMTCT?
- What resources materials exist for PMTCT?
- What organizations in different countries offer training in PMTCT?
- What are the major costs and sources of support for PMTCT?
- What are the major lessons of implementation experience in PMTCT?

## 2. Lessons learned and recommendations

- Prevention works -- countries that successfully link prevention, care, and support programs reap large social and economic benefits
- Investment in prevention among young people is vital and offers the greatest hope for altering the course of the epidemic
- Basic elements of successful prevention programs include communication (including sexual health education) and behavior change, the creation of an enabling socio-political environment for people to protect themselves against the virus, condom promotion, voluntary and confidential counseling and testing, and the treatment of sexually transmitted infections
- Programs should ensure the consistency, relevance, and phasing of messages being disseminated from various sources
- The scope of prevention programs is often inadequate; those most vulnerable to infection and marginalized groups are more likely to be fall beyond the realm of prevention efforts
- PLWHAs can play a critical role in the design and implementation of prevention programs
- Effective prevention is rooted in communities and often originates from grassroots activities and activism
- Programs should be developed with respect to the local context

Support for research (e.g behavioral studies, vaccine trials) is important for balance in the national context





# Chapter 27

## Care and Support

### 1. Introduction

As previously discussed, this chapter is meant to serve as a bookmark.

### 2. Why is care and support important?

**HIV/AIDS care is vital in order to:**

- **Reduce Distress and Improve Health, Productivity and Longevity.** HIV/AIDS care reduces distress and promotes dignity and improves health, productivity and longevity.
- **Decongest Formal Health Services.** An effective continuum of care helps to decongest formal health services already challenged by other demands, while providing effective home and community based care.
- **Address Community Priorities:** Families and communities see care as an urgent priority, which HIV/AIDS programs must address.
- **Reinforce Prevention:** HIV/AIDS care provides important opportunities to strengthen prevention.

### 3. What is HIV/AIDS Care?

#### Levels of Care

HIV/AIDS care spans an increasingly wide and complex range of options. It is helpful to describe the different levels of HIV/AIDS care and to define their key elements, complexity, and costs. Greater understanding of each of the levels assists in ensuring that each level of HIV/AIDS care is appropriately dealt with.

In support of expanding access to the full range of treatment, care, and support services, within the context of local health care systems and national HIV/AIDS strategic plans, WHO and UNAIDS have developed a model to assist in the prioritization of interventions. WHO and UNAIDS suggest three major levels of care. Each level is progressively more complicated and expensive, as indicated in the table below. This table illustrates three broad levels of HIV/AIDS activities classified on the basis of their complexity and cost. Ideally, all components should be provided within health systems, but limited resources require that countries make difficult choices regarding the content and scale of components included in national plans. As more resources become available, HIV/AIDS care, and support interventions can and should be expanded to increase coverage and, where appropriate, additional elements of care should be considered.

Table 27.1

Levels of treatment, care, and support interventions according to need, complexity, and cost	
Essential activities	<ul style="list-style-type: none"> <li>• HIV voluntary counseling and testing</li> <li>• Palliative care and treatment for common opportunistic infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)</li> <li>• Nutritional care</li> <li>• STIs care and family planning services</li> <li>• Cotrimoxazole prophylaxis among PLWHA</li> <li>• Community activities that mitigate the impact of HIV infection (including legal structures against stigma)</li> </ul>
Intermediate complexity and cost	<p>ALL THE ABOVE PLUS</p> <ul style="list-style-type: none"> <li>• Screening for TB among PLWHA and at VCT sites</li> <li>• Preventive therapy for TB among PLWHA</li> <li>• Systemic antifungals for systemic mycosis (such as cryptococcosis)</li> <li>• Treatment of HIV-associated malignancies: Karposi’s sarcoma, lymphoma and cervical cancer</li> <li>• Treatment of extensive herpes</li> <li>• Prevention of mother to child transmission of HIV</li> <li>• Post exposure prophylaxis of occupational exposure to HIV and for rape</li> </ul>
High complexity and cost	<p>ALL THE ABOVE PLUS</p> <ul style="list-style-type: none"> <li>• Triple Anti-Retroviral Therapy</li> <li>• Diagnosis and treatment of opportunistic infections that are difficult to diagnose and expensive to treat such as multi-resistant TB, toxoplasmosis, etc.</li> <li>• Advanced treatment of HIV related malignancies</li> <li>• Specific public services that reduce the economic and social impacts of HIV infection</li> </ul>

*Note: HIV testing of blood supplies, the promotion of universal precautions, and health policy activities, such as the regulation of care delivery and drug supplies, should be undertaken at all levels and consequently are also essential health sector activities. [Source: WHO/UNAIDS (2000). Key elements in HIV/AIDS care and support].*

#### 4. Lessons learned and recommendations

- Building each level of care. Few PLWAs in Africa yet have access to primary palliative care, let alone HAART. It is vital to focus on strengthening each level of care progressively, beginning with universal access to palliative care.
- Strengthening TB Care. There is great scope to improve coordination between palliative care and TB programs and, to assist palliative care programs to manage TB more effectively.

- Balancing prevention and care. Increasing access to HIV/AIDS care must be balanced by a commitment to strengthen HIV prevention.
- The needs of PLWHA and their households extend far beyond access to drugs and health care -- support for social, psychological, and economic consequences is also critical
- The provision of effective treatment, care and support services strengthens overall prevention efforts
- Strong health systems form the basis for comprehensive treatment, care and support programs
- The content and scale of national programs vary with respect to the complexity and cost of components
- Simpler treatment regimens and reductions in drug costs mean that earlier assumptions regarding the feasibility of providing more advanced treatment protocols (such as ART) be re-examined on a country-by-country basis
- Communities and community-based organizations, and PLWHA associations in particular, play a central role in the design, service delivery, and evaluation of effective programs. The role played by traditional healers in communities is important to consider.

## 5. HIV/AIDS Care bookmark questions

### Palliative Care

- What conditions does palliative care address?
- What are the major elements of palliative care?
- What examples of good practice are there in palliative care?
- What resources materials exist for palliative care?
- What organizations in different countries offer training in palliative care?
- What are the major costs and sources of support for palliative care?
- What are the major lessons of experience in palliative care?

### Tuberculosis

- What health system prerequisites are needed before DOTS can be introduced?
- What are the major DOTS drug combinations, what do they cost and how effective are they?
- What examples of good practice are there in DOTS?
- What resource materials exist DOTS?
- What organizations in different countries offer training in DOTS, particularly as it is implemented in developing countries?
- What are the major costs and sources of support for DOTS, including pharmaceutical companies?
- What are the major lessons of experience in DOTS?
- What approaches and lessons may help to ensure expansions of DOTS services?

### Opportunistic Infection Management

- What are the major opportunistic infections associated with HIV/AIDS?
- What treatments are recommended for the major opportunistic infections, what do they cost and how effective are they?
- What examples of good practice are there in opportunistic infection management, particularly TB management?
- What examples exist of effective integration of HIV/AIDS care and TB programs?



- What resource materials exist for opportunistic infection management, particularly TB management?
- What organizations in different countries offer training in opportunistic infection management?
- What are the major costs and sources of support for palliative care?
- What are the major lessons of experience in opportunistic infection management, particularly TB management?

### Prophylaxis/Preventive Therapy

- What are the major conditions that may be addressed by prophylaxis and preventive therapy?
- What are the major prophylactic and preventive strategies, what do they cost and how effective are they?
- What examples of good practice are there in each area of prophylactic and preventive therapy?
- What resource materials exist for prophylaxis and preventive therapy?
- What organizations in different countries offer training in prophylaxis and preventive therapy?
- What are the major costs and sources of support for prophylaxis and preventive therapy?
- What are the major lessons of experience in prophylaxis and preventive therapy?

### ART

- What health system prerequisites are needed before ART is introduced?
- What are the major ART drug combinations, what do they cost and how effective are they?
- What examples of good practice are there in ART?
- What resource materials exist for ART?
- What organizations in different countries offer training in ART, particularly as it is implemented in developing countries?
- What are the major costs and sources of support for ART, including pharmaceutical companies?
- What are the major lessons of experience in ART?
- What approaches and lessons may help to ensure equitable introduction of ART?





# Chapter 28

## Mitigation

### 1. Introduction

As previously indicated, this chapter serves as a bookmark.

### 2. Why mitigation is important?

Although this chapter utilizes the issue of orphans and vulnerable children as an example of critical mitigation needs, it should be noted that mitigation analyses and efforts should be expanded to all sectors (with respect to human resources and planning issues), gender issues, legal frameworks (property rights, etc), and expanded to elderly populations caring for grandchildren, among others.

- **The huge scale of the problem.** More children have been orphaned by AIDS in Africa- about ten million by the end of 2001- then anywhere else. The deep rooted relationship systems that exist in Africa, extended-family networks of aunts and uncles, cousins and grandparents, are an age-old social safety net for children that has long proved itself resilient even to major social changes. This is now unraveling rapidly under the strain of AIDS and the soaring numbers of orphans in the most affected countries.
- **An AIDS-weakened infrastructure.** The impact of the epidemic is felt through out communities and societies, as teachers and farmers, trained health care personnel and workers from all parts of the economy have died and continue to die in enormous numbers. As those dying are usually in their most productive years, many schools, hospitals, private industries and civil services are short staffed. The drain on virtually all segments of communities and nations means that insufficient orphan resources or services remain and fewer can be produced or provided to those in the front line of orphan care.
- **The vulnerability of orphans.** Children who are orphaned by AIDS are often the first to be denied education when their extended families cannot afford to educate them. Children who are orphaned by AIDS may also not receive the health care they need, and sometimes this is because it is assumed they are infected with HIV and their illness is untreatable. Orphans of AIDS are at far greater risk than their peers of eventually becoming infected with HIV. Often emotionally vulnerable and financially desperate, orphaned children are more likely to be sexually abused and forced into abusive situations, such as prostitution, as a means of survival.
- **Grief before death and the tragedy of losing both parents.** A child whose mother or father has HIV begins to experience loss, sorrow and suffering long before the parent's death. Children who live through their parent's pain and illness frequently suffer from depression, stress and anxiety. Many children lose everything that once offered them comfort, security and hope for the future.
- **The AIDS stigma.** the distress and social isolation experienced by children both before and after the death of their parents are strongly exacerbated by the shame, fear and rejection that often surrounds people affected by HIV/AIDS. Because of this stigma and the often irrational fear surrounding AIDS, children may be denied access to schooling and health care.

## 2. What can individual countries do to protect their children?

- **Mobilize political will and reallocate national resources.** Visible and influential leadership is essential to help societies overcome fear and stigma associated with HIV/AIDS infection.
- **Stimulate and strengthen community-based responses to orphan care.** NGOs and community based partners should be supported with technical assistance, policy and planning guidance, training and resources. Community-based care and support are varied; substitute and foster care families, since they are the ones who care for children when family members are not available on an informal or formal basis, child-headed households consisting of children 'parented' by an elder sibling and orphanages - all play an important role in the way to respond.
- **Capacity building of families and communities to care for and support orphans.** Families provide the best environment for bringing up children and, if adequately supported, they will be best able to provide the care that children orphaned by AIDS require. This support should encompass improved access to basic services, including health care, safe water and sanitation and education, as well as assistance with childcare. Policies must be designed to prevent families with orphans from sinking into deep poverty. This may be in the form of income generating activities, small business cooperatives, vocational training and micro-credit schemes. Keeping orphans in school is especially crucial in breaking the poverty cycle.
- **Ensure the government protects the most vulnerable children.** Government commitment to AIDS education and prevention efforts for young people is crucial. Governments also should review and reform laws and policies dealing with children and women, especially the most vulnerable because the deaths in the family commonly leave orphans and widows at risk of losing their inheritance and property rights- often their major sources of income and food. Government monitoring of the impact of HIV/AIDS on children and families is also very important in planning the interventions and determining their effectiveness. Accurate information on the numbers of children orphaned, where they are, the circumstances of their lives and the nature of their needs is vital as an advocacy tool; this information can also help raise awareness about the social impact of AIDS and promote realization of children's rights.
- **Build the capacity for children to realize their rights and fulfill their needs.** It is essential to address the emotional needs of children devastated by their parent's deaths from AIDS. Where possible, emotional support through individual and family counseling should be given to children as well as to their families before the parent's death. Parents with HIV/AIDS must also be helped to come to terms with their approaching death and to plan for their children's welfare.

## 3. Lessons learned and recommendations

- Comprehensive and long-term efforts are needed to mitigate the impact of HIV/AIDS on vulnerable populations
- Efforts to strengthen social safety nets that support orphans and other vulnerable children require a range of interventions that vary both between and within countries
- Programs, particularly with respect to orphans and other vulnerable children, are commonly initiated late in the course of the epidemic, on too small a scale, and have largely been fragmented and short-sighted in their response

- Programs should not single out AIDS orphans in the provision of services but deal with all orphans and vulnerable children
- Institutionalized care for the majority of orphans and other vulnerable children is neither a developmentally ideal nor a financially viable option

Community members should play a key role in determining individuals at greatest risk and in validating what constitutes an appropriate responses and form(s) of assistance

- **Interventions need to be carefully chosen** to address the specific risks faced by orphans in a given country environment and strengthening the existing community coping strategies, rather than supplanting them.
- **There is no single “best practice” option applicable to all countries in all circumstances.** The program choice and the targeting method depend on the country circumstances and the nature and intensity of the problem. For example, in countries like Benin, Gabon, Nigeria, and Togo, many vulnerable children are reportedly being bought and sold for their labor in neighboring countries. Providing care for these children requires a different approach than caring for orphaned children in regions where community structures are still strong.
- **“Fostering” of orphans by relatives is more common in the African socio-cultural setting than most other options.** This is an option that is most prevalent across much of Africa. Orphans are being looked after by the extended family or friends and relatives to the orphans. However, care needs to be taken that fostering does not lead to child abuse.
- **To promote “fostering” in countries in normal or post-conflict country conditions, both direct subsidies and indirect subsidies (such as education fee waivers and food supplements) have a role to play.** Indirect subsidies such as education waivers are preferable because they can be easily monitored to ensure that they benefit the orphan. This minimizes leakage and can be backed by community policing and oversight by NGOs or religious groups. A community driven approach to targeting orphans make sense for identifying orphans and delivering such assistance.
- **Since the families fostering orphans are themselves likely to be poor and vulnerable, efforts to provide income-generating schemes have found success in some countries such as Uganda and Eritrea.** They are unlikely to be effective, however, unless supported by charismatic leadership and followed up with training and marketing support.
- **In countries where orphans are in large numbers and community and household fostering has reached its limits, the case for wider institutional innovations such as children villages appears strong.** There are examples in Eritrea, Uganda, Zambia and the challenge is to keep costs down.
- **Orphanages are very expensive and assessment results show that the children feel stigma.** However, orphanages cannot be ruled out in urban settings. Even for rural settings, the concept of orphanages could be converted to African rural setting by locating “children’s homes” in villages with significant community oversight . Group homes for children such as in Eritrea have been found to be successfully raising orphans towards normal life in villages.

## 4. HIV/AIDS Mitigation bookmark questions

### Social capital

- What are the major elements of social capital?
- What examples of good practice are there in building social capital?
- What resources materials exist for social capital programs?
- What organizations in different countries offer training in social capital analysis and strengthening?
- What are the major costs and sources of support for social capital building programs?
- What are the major lessons of implementation experience in social capital programs?

### Community psychosocial support

- What are the major elements of community psychosocial support programs?
- What examples of good practice are there in community psychosocial support programs?
- What resources materials exist for community psychosocial support programs?
- What organizations in different countries offer training in community psychosocial support?
- What are the major costs and sources of support for community psychosocial support programs?
- What are the major lessons of implementation experience in community psychosocial support programs?

### Food security

- What are the major elements of food security programs?
- What examples of good practice are there in food security programs?
- What resources materials exist for food security programs?
- What organizations in different countries offer training in food security programs?
- What are the major costs and sources of support for food security programs?
- What are the major lessons of implementation experience in food security programs?

### Household income

- What are the major elements of household income programs?
- What examples of good practice are there in household income programs?
- What resources materials exist for household income programs?
- What organizations in different countries offer training in household income programs?
- What are the major costs and sources of support for household income programs?
- What are the major lessons of implementation experience in household income programs?



# Chapter 29

## Early Child Development (ECD)

### What is ECD?

Early child development (ECD) refers to the combination of physical, mental, and social development in the early years of life. During early childhood, patterns of behavior, competency, and learning are initiated and established; socio-environmental factors begin to modify genetic inheritance and brain cells grow in abundance. Any significant gap can have a negative impact on life-long development. The first years last a lifetime.

Early child development includes all interventions directed at children or their caregivers, preferably integrated as a package of services that support the holistic development of the child.

### Why is it important?

Early childhood is the most rapid period of development in human life. For better or worse, the period 0–8 has an enormous effect on the future health, cognitive development, cultural attitudes, and productivity of an individual.

Whereas most HIV/AIDS programs cite coverage for children of all ages and have at least the potential to benefit young children, program elements designed specifically to meet the needs of pre-primary school-aged children are still rare. Few programs adequately recognize and address the needs of young children affected by HIV/AIDS.

If young children affected by HIV/AIDS lack the essential care needed to develop their full potential, they will not have the skills or be equipped to lead productive lives and to better respond to and participate in HIV/AIDS prevention activities. An investment in ECD HIV/AIDS actions at this stage would have multiple, long-term benefits for both individuals and society.

Early child development programs are now recognized as a powerful economic investment. Investments in ECD will not only pave the way for improving individuals' health, mental and physical performance, and productivity, but also, in a major way, help to minimize or even prevent a host of related social problems, including juvenile delinquency, teenage pregnancy, social violence, and HIV/AIDS.

Integrating ECD actions into national multi-sectoral HIV/AIDS programs will strengthen these programs and extend their outreach to the very youngest members of society. Linking these initiatives to other national development efforts will increase the potential for the convergence of services in areas most affected by HIV/AIDS and for the scaling up of ECD activities. Such linkages will ensure that the best interests of all children are served.

### What activities would be undertaken?

Optimally, effective ECD HIV/AIDS interventions should include a combination of economic enhancement, sectoral programs, material and psychological support, and measures to help parents infected with HIV/AIDS live longer.

### Main categories of interventions

- **Delivery of services to young children.** Includes, but is not limited to, food donations, daycare, educational opportunities, social services, protection, and health care. Development of quality ECD centers — to include supportive learning activities, outreach to caregivers, and support for the multiple needs of young children, which include immediate medical care and nutritional support, if needed
- **Education and support for families and caregivers.** May consist of life skills education, counseling, and support for parenting programs; HIV/AIDS prevention messages; information on nutrition, voluntary counseling and testing (VCT), PMTCT, and ART; economic enhancement activities; and psychosocial services.
- **Training and support of care providers.** Includes the building of capacity and development of materials for social workers, health workers, and early childhood educators.
- **Sensitization through the mass media.** May involve a mix of media, including traditional and interpersonal communications or print, radio, and television to; disseminate informative messages on topics that focus on young children and families affected by HIV/AIDS; reduce stigma and discrimination against households that have individuals affected by HIV/AIDS; enforce the legal framework related to protection of young children and property rights; advocate for ratification of policies by government action; and ensure implementation of policies.
- **Community mobilization and strengthening of community-based activities.** May include activities to protect children and improve their care; support for development of partnerships among NGOs, faith based organizations (FBOs), the private sector, and government; and capacity building among community based organizations (CBOs).

### Who would do it?

Direct government HIV/AIDS programs cannot do the job alone. They must collaborate closely and support complementary efforts by NGOs, CBOs, FBOs, traditional leaders, the private sector, people living with HIV/AIDS (PLWHA), and individuals otherwise affected by HIV/AIDS.

Typically, the ECD HIV/AIDS core group that plans program coordination and facilitation consists of: (i) the NAS, the World Bank Task Team leader and team members, UNICEF ECD and HIV/AIDS focal points, sector specialists, and NGO focal points; (ii) sectoral ministries concerned with the welfare of young children and their caregivers; and (iii) local and international HIV/AIDS practitioners. Leadership is provided by the appropriate line substantive expertise, and the NAS.

The core group has at least three audiences it communicates with regularly and engages: (i) community representatives; (ii) government officials at national, regional, district, and municipal levels; and (iii) international collaborators, the UN Theme Group on HIV/AIDS, the Joint United Nations Program on HIV/AIDS (UNAIDS), and bilateral donors.

### Main delivery systems

- Contracts with CSOs, such as NGOs, to implement activities in collaboration with formal and informal community organizations;
- Local grants to communities and to community and private-sector organizations;
- Line ministries' delivery of social services to ECD providers, to include the linking of childcare centers to schools and other components of the formal education system;

- Direct provision of food, money, and technical support by international agencies, local and international NGOs, and private institutions.

### Key Steps to Operationalizing of ECD HIV AIDS Activities:

- Identify relevant ministries that address young children affected by HIV/AIDS.
- Undertake capacity building to strengthen relevant ministries. Identify the skills needed in ministries that are mandated to oversee and/or coordinate ECD programs. Organize sensitization session for key ministries for ECD HIV/AIDS activities. Provide assistance to the ministries to incorporate ECD HIV/AIDS in their initial work plans, focusing on staff knowledge and understanding of the issues and potential responses.
- Identify stakeholders, which may include, but are not limited to, CBOs, the private sector, FBOs, local and international NGOs, and UN agencies [i.e., UNICEF, UNFPA, UNHCR, WFP], and World Health Organization (WHO)].
- Collect baseline data and conduct a situational analysis. Name a “designated champion” (i.e., government entity) responsible for this effort.
- Consolidate available data and develop a national integrated database for tracking the status of children under age 8.
- Prepare a report that consolidates the information collected. Include ongoing and planned programs, as well as constraints that may impede the effective care and support of young children affected by HIV/AIDS.

### What are the major indicators of performance?

National, multi-sectoral ECD HIV/AIDS monitoring must be “realistic”—in terms of the data collection being doable and the activities selected being worthwhile tracking. In other words, the collection of data should be possible, in practical terms, and a responsible entity should ensure that data are collected on a sustained basis and analyzed so that policy and program decision makers can take appropriate action.

Typically, crucial performance indicators for an ECD HIV/AIDS program deal with coverage such as:

- Number of young children and caregivers benefited by social-sector programs;
- Number of young children and caregivers reached by civil society activities;
- Number of communities mobilized to address the most urgent needs of young children affected by AIDS and their caregivers.

Broad indicators may be sufficient for a community mobilization effort, but more specific indicators, if defined by an outside agency, may preclude communities from taking responsibility for sustaining effective action. A recommended approach is to delineate broad indicators at the beginning and then have each community develop specific indicators in relation to these. The specific indicators will reflect a community’s priority concerns and intended actions.

### Specific indicators for evaluating inputs, outputs, and outcomes of ECD HIV/AIDS projects typically are as follows.

#### Input indicators:

- Number of people trained;
- Distribution systems utilized, social support for families available, target populations involved;
- Development of IEC and BCC messages that contain content related to infants, young children, and HIV/AIDS;
- Number of informal groups and CSOs that are assisting with these activities.



**Output indicators:**

- Number of individuals in the targeted cohort who receive full-service care;
- Number of individuals in the targeted cohort who receive outreach services;
- Number and percent of the population that is knowledgeable about (i) the causes of HIV/AIDS, (ii) good care giving practices for young children, and (iii) the needs and vulnerabilities of young children affected by HIV/AIDS.

**Outcome indicators:**

- General public awareness of, sensitization to, and recognition of the importance of the needs of young children infected and affected by HIV/AIDS;
- Number and percent of young children affected by HIV/AIDS who receive some level of improved support;
- Level of malnutrition among young children affected by HIV/AIDS (i.e., percent of children stunted or underweight);
- Number and percent of individuals who change their attitudes and behaviors;
- Increase in financial and human resources provided for ECD support.

**Lessons learned and recommendations****General**

- Young children affected by HIV/AIDS who do not receive adequate health care, nutrition, and psychosocial interaction are likely to be impaired in multiple ways—if they survive.
- The first line of response to HIV/AIDS is affected families and communities. Strengthening the capacities of families and communities is fundamental in responding effectively to HIV/AIDS.
- The impact of adult illness on children begins when a parent is diagnosed or falls ill with HIV/AIDS.
- Stigma, one of the most significant barriers to effective ECD HIV/AIDS activities, should be addressed at the beginning of any planned activity.
- Strategies of community-based support or foster families, or a combination, are usually among the best options for ECD HIV/AIDS. When they include community mobilization and capacity development, these strategies are cost-effective and promote environments that are conducive for the normal development of children.
- Locally initiated programs that are operated by concerned and capable members of households and extended families and community leaders are more meaningful, cost-effective, and sustainable than are formal, national programs.
- Both governments and donor agencies consider institutional care to be a last resort and a temporary measure until a permanent placement can be identified for a child.
- External funding in appropriate amounts and at the right time can help to facilitate, strengthen, and support community activities, but it should not be used to lead a community mobilization process. Otherwise, communities start, and continue, to be dependent on external financial resources.
- Projects that have community support invariably begin slowly, but ultimately are more sustainable than projects that do not have this support. Losing time in the initial stage of a project is far better than not having the support of the community for an entire project

**Program content**

- Prevention activities should be incorporated into all ECD interventions from the beginning. Care and support activities can often be good entry points for discussing HIV/AIDS issues and promoting prevention measures.
- Quality of care can be improved with standardized training.
- Youth, especially those responsible for the care of younger children, should be involved and supported by ECD HIV/AIDS programs. Youth should be seen as part of the solution. They should be supported to play leadership roles in program planning, public education, advocacy, and evaluation.

### Program monitoring and evaluation

- Qualitative information about a community's perception of a program is as important as quantitative information.
- M&E should be up-front, participatory, and linked to decisions about children and programs.
- Programmers must develop approaches for documenting the long-term effects of programs.
- Indices of the vulnerability of children and communities should be developed for use in mapping and establishing geographic priorities for interventions.
- Process, approaches, and models should be tailored to the environment-urban, peri-urban, or rural.



See Sub-manual (CD-ROM) on Operational Guidelines for Supporting Early Child Development (ECD) in Multi-sectoral HIV/AIDS Programs in Africa for further references





# Chapter 30

## Refugees

### What is Involved?

Hundreds of millions of persons are currently affected worldwide by armed conflict, both directly and indirectly. Conflict sends people fleeing to seek refuge either within their own country as internally displaced persons (IDPs) or across an international border to become refugees. Sub Saharan Africa (SSA) is disproportionately affected by the HIV/AIDS epidemic, poverty and armed conflict. In areas with high HIV prevalence and conflict, such as in SSA, HIV/AIDS may act as a double edged sword. The epidemiology of HIV/AIDS during conflict is complicated, but conflict has been shown to be associated with several factors that render affected populations more vulnerable to HIV transmission. In addition, HIV/AIDS may reduce the coping mechanisms and resilience of populations affected by conflicts. While persons affected by conflict do not necessarily have high HIV prevalence rates, they are linked to any successful effort to combat the catastrophic epidemic and must be included in all HIV/AIDS programming.<sup>6</sup> Forced migrant populations have complex interactions with various communities and high risk groups with whom they come into contact

### Why is it Important?

Refugees have been excluded from many asylum country HIV/AIDS National Strategic Plans, their needs have not been addressed in proposals submitted to major donors.<sup>6</sup> Refugees and local populations interact on a daily basis. Failing to address this population undermines effective national HIV/AIDS prevention and care efforts. Furthermore, refugees are often hosted in remote and inaccessible areas, far from cities where HIV/AIDS programs are most developed. Improving HIV/AIDS interventions for refugees in an integrated manner with the surrounding host population will invariably improve services for both communities. Population groups which are particularly affected include:

#### Women

Women are at increased risk of sexual violence and abuse. Food insecurity, hunger, and unequal distribution of material goods put women and girls at risk of exploitation and abuse, including coercion into transactional sex for survival. Displacement may cause families and communities to split apart, destroying community structures and support systems that traditionally serve to protect women and children. This breakdown of communities may also lead men and women to engage in risky sexual behaviours. Women and children form the majority of displaced populations worldwide, as male family members are more likely to be involved in the conflict itself. Displaced women often find themselves as new heads of household, now responsible for providing for their families in addition to caring for their children. Targeted HIV/AIDS interventions that protect, train and educate women are essential.

#### Children

In high HIV prevalence and conflict areas, the vulnerability of children increases and the number of orphans due to the death of one or both parents may rise. Educational opportunities may be limited in conflict situations. As with women, displaced children, particularly orphans and children made vulnerable by HIV/AIDS, are at increased risk for many types of abuse and exploitation, and may be coerced into transactional sex for survival. Additionally, the abusive use of children as soldiers and the extreme actions they are led to commit put this group at increased risk of contracting HIV.

### Armed Personnel

Armed personnel may be a significant vector of transmission of sexually transmitted infections (STIs), including HIV, among conflict-affected and displaced populations. (HIV prevalence rates among some countries' militaries have been documented to be 2-5 times greater than their respective civilian populations.) Many intra-state conflicts have undisciplined, irregular armies and militias. Further, peacekeepers coming from high prevalence HIV countries may also transmit HIV to conflict-affected and displaced populations because of their access to civilians, money and power. Conversely, those from low prevalence HIV countries may be at increased risk of contracting the virus.

### Humanitarian Workers

Humanitarian staff working in conflict situations often find themselves in isolated, unstable and unfamiliar surroundings. They may face increased occupational exposure to HIV in the health care setting as well as increased exposure to sexual violence. Furthermore, they may undertake high risk sexual behaviour which they might normally avoid.

## What Activities?

UNHCR has developed a framework for assessment of and planning for HIV/AIDS in conflict and displaced person situations (See Annex for "HIV/AIDS and Conflict/Displaced Persons Assessment and Planning Tool Framework"). It covers the most important HIV/AIDS interventions in a hierarchal fashion. It takes as its point of departure that minimum essential HIV/AIDS interventions must be provided before comprehensive activities are initiated. This focused, hierarchal approach is essential, given the security and resource constraints in, and the remoteness of, most conflict and displaced persons situations. Essential services (e.g. safe blood supply, universal precautions, treatment for STIs, condom distribution, information-education-communication materials) must be made available before more complicated and resource intensive interventions, such as prevention of mother-to-child transmission (PMTCT) or long term antiretroviral therapy (ART), are provided.

Ultimately comprehensive programs that link HIV/AIDS prevention with care and treatment programmes, and conflict affected and displaced populations should be included, once the minimum HIV/AIDS activities have been implemented. Interventions ranging from voluntary counselling and testing (VCT), PMTCT, behavioural and sentinel surveillance, population-based surveys, and even ART have been implemented among such populations in the past few years in some circumstances.

Antiretroviral treatment (ART) is more complex in humanitarian settings than in typical resource poor settings due to migration and the consequent difficulties with access and follow-up. Pilot projects are necessary to examine modalities of drug distribution and other logistical factors, laboratory, compliance, surveillance, side effects, and resistance. A community-based infrastructure adapted to the specific situation should be employed. For the most part in conflict settings and for displaced populations, existing national protocols and guidelines of the host country should be followed. However, at times such protocols and guidelines do not exist, are outdated or are not being implemented in the remote areas in which refugees and IDPS are situated. Different languages and cultures require a modification of IEC materials and other interventions to suit the varied populations that are mixed together in conflict settings. The interaction between displaced persons and the surrounding population requires strong coordination and cooperation among the host government, international and local organisations and the communities themselves. Ultimately, the repatriation of refugees pose a particular problem, as they often return to countries that have fewer resources than the host country. Therefore, in the near term refugees may be receiving ART in host countries but may not be able to continue when they return to their country of origin. On the other hand, one never knows how long refugees will remain in host countries and they should have the same opportunity to benefit from ART as the surrounding host population. (UNHCR is currently developing an ART policy for refugees.)

A broader approach to fighting the HIV/AIDS epidemic across international boundaries will be needed. Recent conflicts in Ivory Coast, Liberia, and DRC, for example, saw armed military groups, refugees and economic migrants moving across many

borders in West and Central Africa. Country by country plans will not be sufficient and therefore subregional approaches will be needed in conflict and displaced situations to effectively combat the epidemic. Some sub regional initiatives, such as the Great Lakes Initiative on AIDS (GLIA), the Abidjan/Lagos HIV/AIDS Transport Corridor Project, the Oubangi-Chiari HIV/AIDS Initiative, and the Mano River Union Initiative on HIV/AIDS are either in the early stages of execution or development. Thus there is not yet a significant body of experience in dealing with subregional efforts

*See page 167-169 for a Matrix for HIV/AIDS Interventions for Emergency Settings.*

## Who Does It?

Coordination and integration are key components in conflict and displaced settings given their multisectoral and cross border nature. In these settings, numerous disparate groups must come together to improve their communication and coordination and to integrate their activities. These varied actors include:

1. NGOs, including relief and development agencies.
2. UN agencies and international organisations.
3. Government agencies especially those involved in HIV/AIDS, interior, social welfare, health and education as well as political leaders.
4. Donors.
5. Health professionals, lawyers, anthropologists, teachers, and religious leaders.
6. Armed groups in conflict.
7. Refugees, IDPS and local surrounding populations.

Coordination and integration must occur at all levels. The following are examples:

### At Local and Provincial level

Multisectoral HIV/AIDS committees that include a wide range of persons in the community including service providers, political and religious leaders, women's groups, students, youth, teachers, and all conflict-affected communities.

### At National level

National HIV/AIDS program managers and policy oversight bodies (National AIDS Commissions-NAC), relevant public sector partners such as the ministries of health, interior, defense, as well as UNAIDS, the UN Theme Group on HIV/AIDS and associated technical working groups

### At Sub-regional/Regional level

Various subregional initiatives such as the Great Lakes Initiative on HIV/AIDS, the Mano River Union, the Inter-Governmental Authority on Development, and UNAIDS Inter-Country Teams

## What Can Be Monitored and Evaluated?

Despite the difficulties of undertaking assessments, monitoring and evaluation (M&E) in conflict and displaced persons settings, it is possible to carry out HIV sentinel surveillance surveys, HIV population-based surveys and HIV behavioural surveillance surveys in conflict and displaced persons settings. Such behavioural and serological surveillance allows organisations to prioritize and target programs, provide a baseline and trends to evaluate their effectiveness, and act as an advocacy tool. And, such data allow better understanding of the complex interactions between conflict, displacement and the transmission of HIV that will ultimately allow us to better combat the epidemic.

UNHCR, WFP and UNICEF recently undertook a joint HIV/AIDS, food and nutrition operational research project in Zambia and Uganda to explore options for effective use of food aid to improve HIV/AIDS prevention, care and treatment in refugee camp settings. (Results will be ready in 2004).

## Lessons Learned and Recommendations

The matrix on page 163 captures the basic different types of responses in different specific settings.

The general basic recommendations are that:

1. Conflict-affected and displaced populations (over 10,000) be covered by national HIV/AIDS strategic plans, proposals and interventions;
2. b)essential interventions for these populations should be put in place first , then supported by pilot projects for more comprehensive HIV/AIDS interventions, and
3. c) these situations require responses that extend beyond national boundaries.



Table 30.1

## Matrix for HIV/AIDS Interventions in Emergency Settings

Sectoral Response	Emergency preparedness	Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
1. Coordination	<ul style="list-style-type: none"> <li>Determine coordination structures</li> <li>Identify and list partners</li> <li>Establish network of resource persons</li> <li>Raise funds</li> <li>Prepare contingency plans</li> <li>Include HIV/AIDS in humanitarian action plans and train accordingly relief workers</li> </ul>	1.1 Establish coordination mechanism	<ul style="list-style-type: none"> <li>Continue fundraising</li> <li>Strengthen networks</li> <li>Enhance information sharing</li> <li>Build human capacity</li> <li>Link emergency to development HIV action</li> <li>Work with authorities</li> <li>Assist government and non-state entities to promote and protect human rights<sup>4</sup></li> </ul>
2. Assessment and monitoring	<ul style="list-style-type: none"> <li>Conduct capacity and situation analysis</li> <li>Develop indicators and tools</li> <li>Involve local institutions and beneficiaries</li> </ul>	2.1 Assess baseline data 2.2 Set up and manage a shared database 2.3 Monitor activities	<ul style="list-style-type: none"> <li>Maintain database</li> <li>Monitor and evaluate all programmes</li> <li>Assess data on prevalence, knowledge attitudes and practice, and impact of HIV/AIDS</li> <li>Draw lessons from evaluations</li> </ul>
3. Protection	<ul style="list-style-type: none"> <li>Review existing protection laws and policies</li> <li>Promote human rights and best practices</li> <li>Ensure that humanitarian activities minimize the risk of sexual violence, and exploitation, and HIV-related discrimination</li> <li>Train uniformed forces and humanitarian workers on HIV/AIDS and sexual violence</li> </ul>	3.1 Prevent and respond to sexual violence and exploitation 3.2 Protect orphans and separated children 3.3 Ensure access to condoms for peacekeepers, military and humanitarian staff	<ul style="list-style-type: none"> <li>Involve authorities to reduce HIV-related discrimination</li> <li>Expand prevention and response to sexual violence and exploitation</li> <li>Strengthen protection for orphans, separated children and young people</li> <li>Institutionalize training for uniformed forces on HIV/AIDS, sexual violence and exploitation, and non-discrimination</li> <li>Put in place HIV-related services for demobilized personnel</li> <li>Strengthen IDP/refugee response</li> </ul>



Table 30.1 *Continued*

Sectoral Response	Emergency preparedness	Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
4. Water and sanitation	<ul style="list-style-type: none"> <li>• Train staff on HIV/AIDS, sexual violence, gender, and non-discrimination</li> </ul>	4.1 Include HIV considerations in water/sanitation planning	<ul style="list-style-type: none"> <li>• Establish water/sanitation management committees</li> <li>• Organize awareness campaigns on hygiene and sanitation, targeting people affected by HIV</li> </ul>
5. Food security and nutrition	<ul style="list-style-type: none"> <li>• Contingency planning/preposition supplies</li> <li>• Train staff on special needs of HIV/AIDS affected populations</li> <li>• Include information about nutritional care and support of PLWHA in community nutrition education programmes</li> <li>• Support food security of HIV/AIDS-affected households</li> <li>• Ensure safety of potential sites</li> <li>• Train staff on HIV/AIDS, gender and non-discrimination</li> </ul>	5.1 Target food aid to affected and at-risk households and communities 5.2 Plan nutrition and food needs for population with high HIV prevalence 5.3 Promote appropriate care and feeding practices for PLWHA 5.4 Support and protect food security of HIV/AIDS affected & at risk households and communities 5.5 Distribute food aid to affected households and communities	<ul style="list-style-type: none"> <li>• Develop strategy to protect long-term food security of HIV affected people</li> <li>• Develop strategies and target vulnerable groups for agricultural extension programmes</li> <li>• Collaborate with community and home based care programmes in providing nutritional support</li> <li>• Assist the government in fulfilling its obligation to respect the human right to food</li> </ul>
6. Shelter and site planning	<ul style="list-style-type: none"> <li>• Ensure safety of potential sites</li> <li>• Train staff on HIV/AIDS, gender and non-discrimination</li> </ul>	6.1 Establish safely designed sites	<ul style="list-style-type: none"> <li>• Plan orderly movement of displaced</li> </ul>
7. Health	<ul style="list-style-type: none"> <li>• Map current services and practices</li> <li>• Plan and stock medical and RH supplies</li> <li>• Adapt/develop protocols</li> <li>• Train health personnel</li> <li>• Plan quality assurance mechanisms</li> <li>• Train staff on the issue of SGBV and the link with HIV/AIDS</li> <li>• Determine prevalence of injecting drug use</li> <li>• Develop instruction leaflets on cleaning injecting materials</li> <li>• Map and support prevention and care initiatives</li> <li>• Train staff and peer educators</li> </ul>	7.1 Ensure access to basic health care for the most vulnerable  7.2 Ensure a safe blood supply  7.3 Provide condoms  7.4 Institute syndromic STI treatment	<ul style="list-style-type: none"> <li>• Forecast longer-term needs; secure regular supplies; ensure appropriate training of the staff</li> <li>• Palliative care and home based care</li> <li>• Treatment of opportunistic infections and TB control programmes</li> <li>• Provision of ARV treatment</li> <li>• Safe blood transfusion services</li> <li>• Ensure regular supplies, include condoms with other RH activities</li> <li>• Reassess condoms based on demand</li> <li>• Management of STI, including condoms</li> <li>• Comprehensive sexual violence programmes</li> </ul>

Table 30.1 *Continued*

Sectoral Response	Emergency preparedness	Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
7. Health continued	<ul style="list-style-type: none"> <li>• Train health staff on RH issues linked with emergencies and the use of RH kits</li> <li>• Assess current practices in the application of universal precautions</li> </ul>	<p>7.5 Ensure IDU appropriate care</p> <p>7.6 Management of the consequences of SV</p> <p>7.7 Ensure safe deliveries</p> <p>7.8 Universal precautions</p>	<ul style="list-style-type: none"> <li>• Comprehensive sexual violence programmes</li> <li>• Control drug trafficking in camp settings</li> <li>• Use peer educators to provide counselling and education on risk reduction strategies</li> <li>• Voluntary counselling and testing</li> <li>• Reproductive health services for young people</li> <li>• Prevention of mother to child transmission</li> <li>• Enable/monitor/reinforce universal precautions in health care</li> </ul>
8. Education	<ul style="list-style-type: none"> <li>• Determine emergency education options for boys and girls</li> <li>• Train teachers on HIV/AIDS and sexual violence and exploitation</li> </ul>	8.1 Ensure children's access to education	<ul style="list-style-type: none"> <li>• Educate girls and boys (formal and non-formal)</li> <li>• Provide lifeskills-based HIV/AIDS education</li> <li>• Monitor and respond to sexual violence and exploitation in educational settings</li> </ul>
9. Behaviour communication change and information education communication	<ul style="list-style-type: none"> <li>• Prepare culturally appropriate messages in local languages</li> <li>• Prepare a basic BCC/IEC strategy</li> <li>• Involve key beneficiaries</li> <li>• Conduct awareness campaigns</li> <li>• Store key documents outside potential emergency areas</li> </ul>		<ul style="list-style-type: none"> <li>• Scale up BCC/IEC</li> <li>• Monitor and evaluate activities</li> </ul>
10. HIV/AIDS in the workplace	<ul style="list-style-type: none"> <li>• Review personnel policies regarding the management of PLWHA who work in humanitarian operations</li> <li>• Develop policies when there are none, aimed at minimising the potential for discrimination</li> <li>• Stock materials for post-exposure prophylaxis (PEP)</li> </ul>	<p>10.1 Prevent discrimination by HIV status in staff management</p> <p>10.2 Provide post-exposure prophylaxis (PEP) available for humanitarian staff</p>	<ul style="list-style-type: none"> <li>• Build capacity of supporting groups for PLWHA and their families</li> <li>• Establish workplace policies to eliminate discrimination against PLWHA</li> <li>• Post-exposure prophylaxis for all humanitarian workers available on regular basis</li> </ul>

